Supreme Court, U.S.
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No. 96-_____

In the
Supreme Court of the United States
October Term, 1996

GARY LEE, M.D., individually and on behalf of his terminally ill patients; WILLIAM PETTY, M.D., individually and on behalf of his terminally ill patients; JANICE ELSNER, individually and as representative of a class of terminally-ill patients; et al.,

Petitioners,

v.

DOUGLAS F. HARCLEROAD, et al.,

Respondents.

On Petition for a Writ of Certiorari to the
United States Court of Appeals for the Ninth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Janice Elsner is dying. Recurring clinical depression makes her vacillate between wanting suicide and life. Oregon's Measure 16 imposes lower medical, psychiatric, and intervention standards if she seeks suicide assistance than non-terminally ill suicidal persons possess. Does Janice have standing to challenge Measure 16 on equal protection, due process, and statutory grounds, both individually and as representative of a class?

2. Drs. Gary Lee and William Petty assert their terminally-ill patients' interests in equal protection, due process, and statutory challenges to Measure 16, but the appeals court held they had no standing because their patients would be "no closer to suffering the asserted injury than Elsner." May these physicians assert third party standing?

3. Health care providers claim Measure 16 violates their rights to freedom of religion and association by requiring forced participation in and association with assisted suicide. The appeals court decided they had no standing and their claim was not ripe because they were subject to no penalty for refusal to participate, but there are serious penalties. Do the health care providers have standing to challenge Measure 16 and is their challenge ripe?

LIST OF PARTIES

Petitioners:

- Gary Lee, M.D., individually and on behalf of his terminally ill patients,
- William Petty, M.D., individually and on behalf of his terminally ill patients,
- Janice Elsner, individually and as representative of a class of terminally-ill patients,
- Fritz Beck,
- June Beck,
- The Willows Home, Inc.,
- Sister Geraldine Bernards, individually and as Administrator of Maryville Nursing Home, Inc., and
- Maryville Nursing Home, Inc.

Respondents:[1]

- Douglas F. Harcleroad, in his official capacity as the District Attorney for Lane County, Oregon, and as representative of the class of all district attorneys in the State of Oregon,
- Members of the Oregon Board of Medical Examiners,
- Peter Goodwin (intervenor),
- Barbara Coombs Lee (intervenor),

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[1]The members of the Oregon Board of Medical Examiners are listed by office only. S. Ct. Rule 35.4. They were listed in the lower courts as follows: Terry L. Connor, D.O., in his official capacity as Chairman of the Oregon Board of Medical Examiners; Edward a. Heusch, in his official capacity as Vice-Chairman of the Oregon Board of Medical Examiners; Catherine M. Nater, in her official capacity as Secretary of the Oregon Board of Medical Examiners; and John W. Gregsby, M.D., Sarah S. Hendrickson, M.D., George a Porter, M.D., James H. Sampson, M.D., Rosemary C. Lee Selinger, M.D., Fred R. Stark, M.D., Maralyn E. Turner, M.D., and J. Bruce Williams, M.D., in their official capacity as members of the Board of Medical Examiners.

- Elven Sinnard (intervenor),
- Ted Levin, M.D. (intervenor), and
- Tim Schuck (intervenor).

LIST OF CORPORATIONS

The Willows Home, Inc. has no parent company and no subsidiaries.

The parent company of Maryville Nursing Home, Inc. is Sisters of St. Mary of Oregon, an Oregon nonprofit religious corporation. Maryville Nursing Home, Inc. has no subsidiaries.

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PETITION FOR A WRIT OF CERTIORARI

Petitioners respectfully request a writ of certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit in this case.

OPINIONS AND ORDERS BELOW

The order of the court of appeals denying rehearing is unreported. App. 67a. The opinion of the court of appeals vacating and remanding the district court decision is reported at 107 F.3d 1382. App. 1a.

The order of the district court granting declaratory judgment and permanent injunction is reported at 891 F. Supp. 1439. App. 35a. The opinion of the district court containing its equal protection analysis is reported at 891 F. Supp. 1429. App. 37a. The opinion of the district court containing its standing analysis is reported at 891 F. Supp. 1421. App. 56a. The opinion of the district court granting a preliminary injunction is reported at 891 F. Supp. 1429.

JURISDICTION

The opinion and judgment of the court of appeals was filed on February 27, 1997. App. 1a. Petitioners Lee et al. filed a timely petition for rehearing. App. 72a. Rehearing was denied on April 11, 1997. App. 67a. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL & STATUTORY PROVISIONS

Article III, Section 2, of the Constitution of the United States of America reads in pertinent part: "The judicial Power shall extend to all Cases, in Law and Equity, arising under this Constitution, the laws of the United States, and Treaties made, or which shall be made, under their Authority . . . ."

Oregon's 1994 Ballot Measure 16, entitled "The Oregon Death with Dignity Act," is set forth as an appendix to the court of appeals opinion. App. 20a.

STATEMENT OF THE CASE

Janice Elsner is dying from progressive muscular dystrophy. Recurrent clinical depression makes Janice vacillate between wanting suicide and life.[2] *See infra.*

Janice has an imminent and substantial risk of death if Oregon's Ballot Measure 16 (authorizing assisted suicide) goes into effect because it doesn't even require psychiatric examination for depression if persons request suicide assistance. If persons not terminally ill request suicide assistance, they are immediately subject to crisis intervention and civil commitment for evaluation and treatment by a mental health professional. This squares with the scientific reality that nearly all persons seeking suicide do so because of depression. Suicidologists say this is also true of terminally ill persons: nearly all who are suicidal will no longer be so if their depression is treated. *See infra.*

Oregon thinks assisted suicide poses such serious dangers to its citizens that it bans it for everyone in Oregon — except for terminally ill persons like Janice, who are highly subject to suicidal depression. Measure 16 imposes lower medical, psychiatric, and intervention standards if Janice seeks suicide assistance than non-terminally ill suicidal persons possess. *See infra.*

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[2]Another terminally-ill plaintiff, Eric Dutson, has already died of AIDS. Dutson also had a history of recurrent clinical depression.

A. Measure 16

Measure 16 was narrowly enacted by Oregon voters on November 8, 1994. It created a scheme of state-authorized, state-regulated, physician-assisted suicide, purportedly limited to terminally-ill, "capable," adults. § 2.01; App. 22a. The entire scheme is set out in the Appendix. App. 20a. The "safeguards" intended to limit assisted suicide to the "capable" are set out in Section 3 of Measure 16. App. 24a.

Conspicuously absent are *any* safeguards at the most critical time, when the lethal prescription is *consumed*. The lethal prescription may be consumed days, weeks, or months after it is obtained, and no effort is made to assure mental competence, to ascertain that the prognosis of death within six months is yet accurate, or to prevent undue influence or coercion.

For the time when the lethal prescription is *dispensed*, certain "safeguards" apply. The evaluation of whether a patient has a "terminal disease" and is "capable" is made by the "attending physician." § 3.01; App. 24a. Confirmation of these diagnoses is made by a "consulting physician" chosen by the "attending physician." § 3.01; App. 24a. These persons making psychiatric or psychological evaluations are primary-care physicians. There is no requirement that a psychiatrist or psychologist make the diagnosis of whether a suicidal person "may be suffering from a psychiatric or psychological disorder, or depression causing impaired judgment." § 3.03; App. 25a. The request for a lethal prescription must be in writing, witnessed by two persons, neither of whom is required to be a mental health professional. § 2.02; App. 23a. There is no requirement that family members — or a court-appointed guardian — be notified, although the patient is invited to contact her family. § 3.05; App. 26a. Fifteen days must elapse between the patient's first oral request for suicide assistance and the writing of the lethal prescription, and within this time 48 hours

must elapse between the written request and writing of the prescription. § 3.08; App. 27a.

Lowered standards of care are created by Measure 16, for the purpose of inducing physicians to participate in the scheme. Appellants' Brief at 20, *Lee v. Oregon*, 107 F.3d 1382. Although physicians are ordinarily subject to the prevailing objective standard of medical care, *see infra*, physicians assisting suicidal persons who are terminally ill need only meet a subjective, "good faith" standard of care. § 4.01; App. 30a. This reduced standard of care applies to the diagnoses of whether a person is terminally ill (having less than six months to live)[3] and whether she is "capable," as well as to the effectiveness of the lethal prescription (which could leave the patient badly damaged and in a coma instead of dead).[4] The protections for the physician extend to: (1) "civil or criminal liability or professional disciplinary action" and (2) "censure, discipline, suspension, loss of license, loss of privilege, loss of membership or other penalty" by any "professional organization or association, or health care provider." § 4.01; App. 30a.

A conscience exemption is provided in Measure 16, but it applies only "to participat[ion] in the provision to a qualified patient of medication to end his or her life." § 4.01; App. 30a. By its terms, it applies only to the actual act of providing the lethal prescription, not myriad other types of complicity in

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[3]There is evidence in the record that it is extremely difficult for a physician to accurately diagnose whether a patient has less than six months to live, and misdiagnoses are common. *Affidavit of Richard Fenigsen, M.D., Ph.D.* Thus, many will "qualify" for assistance in suicide who have an extended lifespan remaining, and tragically premature deaths will occur.

[4]There is evidence in the record that 25% of the suicides by the oral ingestion of lethal substances that Measure 16 prescribes will fail, raising the specter of patient coma, renal damage, toxic psychosis, serious central nervous system damage, and protracted suffering for the patient and her family. *Affidavit of Jerome R. Wernow.*

assisted suicide. For example, a physician would be required to advise qualified patients of this option or suffer a variety of penalties and a religious nursing home would be required to permit assisted suicide in its facility and even provide a witness despite religious objections. § 2.02(4); App. 23a.

B. Proceedings Below

On November 23, 1994, fifteen days before Measure 16 was scheduled to go into effect, plaintiffs filed suit. The claims were brought under 42 U.S.C. § 1983, and jurisdiction was invoked under 28 U.S.C. § 1343.

Concerned about the risk to her life and her second-class status under Measure 16, Janice Elsner challenged the law for violating her federal equal protection and due process constitutional rights (Fourteenth Amendment), as well as the Americans With Disabilities Act of 1990 (42 U.S.C. § 1201 et seq.) and Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 791 et seq.).

Janice was joined in the suit by Drs. Gary Lee and William Petty, who asserted the rights of their terminally patients under the same theories used by Janice Elsner. Also joining in the suit were two residential care facilities, The Willows Home, Inc. and Maryville Nursing Home, Inc., as well as administrators of the facilities, Fritz and June Beck and Sister Geraldine Bernards. All of these health and residential care providers alleged that Measure 16 violates their rights to freedom of religion (under both the First Amendment and Religious Freedom Restoration Act of 1993, § 2000bb et seq.) and association (First Amendment) by requiring forced participation in and association with assisted suicide.

On December 27, 1994, the district court granted preliminary injunctive relief to plaintiffs. *Lee v. Oregon*, 869 F. Supp. 1492. On August 3, 1995, the district court granted summary judgment to plaintiffs and entered a declaratory judgment and

a permanent injunction against implementation of Measure 16. App. 35a. The district court held that Measure 16 violated the Equal Protection Clause and enjoined defendants from recognizing the constitutionality of Measure 16 in their enforcement decisions. *Id.*

The district court devoted an entire opinion to its equal protection analysis. App. 37a. It did not reach plaintiffs' other claims because it found equal protection sufficient to resolve the case. App. 53a. The trial court issued another, separate opinion on standing. App. 56. It found that Janice Elsner had standing to challenge the Act because she suffered an actual and imminent injury under Measure 16, including a risk of death and present lowered standards of care for terminally-ill persons who might seek assistance in suicide. App. 59a-62a, 66a. It held that Dr. Petty, Maryville Nursing Home, Sister Geraldine Bernards, The Willows Home, and Fritz and June Beck had standing to raise First Amendment and Religious Freedom Restoration Act claims. App. 66a. It held that Drs. Lee and Petty did not have standing to raise claims on behalf of their patients. App. 63a-64a. In a separate order, the district court dismissed as moot plaintiffs' motion to certify a class of terminally-ill persons.

The respondents before this Court appealed to the Ninth Circuit Court of Appeals. Petitioners cross-appealed the denial of third-party standing for the physicians to represent the rights of their terminally-ill patients and the denial of class certification.

On February 27, 1997, the Ninth Circuit reversed the district court on standing grounds, holding that no plaintiff had standing to challenge Measure 16. App. 1a. Specifically, the Ninth Circuit held that Janice Elsner had not "made an *individualized* showing that there was a very significant possibility that the future harm will ensue." App. 12a (emphasis in original; internal quotation marks omitted). It decided that Drs. Lee and Petty could not assert the rights of their terminally-ill patients

because their patients would be "no closer to suffering the asserted injury than Elsner." App. 15a. The Ninth Circuit decided that Dr. Petty and residential care providers did not have standing "because Measure does not provide any penalty, criminal or otherwise, for a violation of the challenged provisions." App. 18a. For the same reason the appellate court decided these Plaintiffs' case was not ripe, i.e., "because Plaintiffs have not identified any hardship that would befall them if their claims were not considered at this time." App. 18a. The Ninth Circuit rejected the cross appeal for certification of a class of terminally-ill persons on the basis that Janice Elsner did not have standing herself. App. 15a.

On March 13, 1997, Elsner et al. filed a timely petition for rehearing, focusing at length on standing and indicating matters overlooked by the court of appeals. App. 72a. On April 11, 1997, the Ninth Circuit denied the petition for rehearing. App. 67a.

The mandate did not issue on April 18, 1997, as scheduled, because the Ninth Circuit granted a stay of the mandate for thirty days to allow filing of the present petition and thereafter until the conclusion of this Court's consideration of the case.

REASONS FOR GRANTING THE PETITION

I. This case involves matters of great public importance that have not been, but should be, settled by this Court.

This case involves issues of immense personal and public importance:

1. Whether Janice Elsner will be protected from unwanted death;
2. Whether Janice Elsner will have her day in court to challenge Oregon's Measure 16, which

(a) immediately strips her of presumptions about and protections from suicide and assistance in suicide which are enjoyed by Oregon residents who are not terminally ill and puts her at imminent and substantial risk for unwanted death,

(b) immediately strips her of the medical standard of care afforded persons not terminally ill, by imposing a lower, good-faith, subjective standard, and

(c) immediately strips her and her estate of legal redress available to persons not terminally ill, by imposing a lower, good-faith, subjective standard;

3. Whether a state has an equal protection duty to protect terminally ill persons from unwanted death to the same extent it protects persons who are not terminally ill; and

4. Whether health care providers have standing to challenge Measure 16 for immediately forcing them into complicity with assisted suicide against their consciences by a variety of types of required participation in assisted suicide. Under Measure 16, there is no protection from criminal, disciplinary, and malpractice liability for refusal to participate in actions such as advising a patient of the option of assisted suicide in the informed consent dialogue.

From a broader perspective, this case is "certworthy" because it involves two "important question[s] of federal law that ha[ve] not been, but should be, settled by this Court," S. Ct. Rule 10 (c):

1. May a state create a state-authorized and regulated scheme of assisted suicide, and, if so, what minimal safeguards are necessary to protect the constitutional rights of terminally ill persons and for the statute to pass constitutional scrutiny at any level? If this Court determines that Janice Elsner or another plaintiff has stand-

ing, it may decide this underlying issue of the constitutionality of Measure 16, if it chooses.

2. May a state-authorized regime of assisted suicide be challenged for constitutionality, and, if so, by whom?

As to the underlying assisted suicide issue, it is a life-and-death issue for Janice Elsner, as it is for all terminally-ill persons in Oregon who are at risk for unwanted death as a result of undiagnosed, suicidal depression and are stripped of protections afforded others not terminally ill. It is especially a life-and-death issue for terminally-ill persons who have recurring suicidal depression, as Elsner does. Physician assisted suicide is a vital issue for the United States of America because this is the first venture of a state into an area which has been off limits for over two millennia, since the widespread adoption of the principle underlying the Hippocratic Oath.

While this Court has before it two cases involving assisted suicide, neither governs the present case. Both *Washington v. Glucksberg*, No. 96-110, and *Vacco v. Quill*, No. 95-1858, involve assertions that the states must permit assisted suicide as a constitutional right. Regardless of the outcome of those cases, this case is the next logical consideration.

If there *is* a constitutional right to assisted suicide, may states implement a regime of state-authorized assisted suicide in such a way as to violate the right of terminally ill persons to the equal protection of the laws by putting them at unreasonable risk for unwanted death?

If there is *no* constitutional right to assisted suicide, is the right to life guaranteed by the Fourteenth Amendment alienable, or is it inalienable, like the freedoms against slavery, cruel and

unusual punishment, and government established religion?[5] If the right to life may be alienated and states may permit assisted suicide, are there minimal protections which must be afforded persons in order for the state-authorized scheme to meet scrutiny for rationality? If a state sets for itself the goal of Measure 16, to allow only "capable" persons to have help in killing themselves, is it constitutionally relevant that the "safeguards" purporting to screen out persons not mentally "capable" are wholly inadequate and ineffective — and wholly absent at the subsequent, critical time when the lethal prescription is taken? May a state-endorsed and regulated assisted suicide scheme ignore the findings of modern suicidology and operate on irrational stereotypes? May states create lower standards of medical care for persons within the class defined, as Oregon has done?

As to the question of who, if anyone, may challenge a state-imposed assisted suicide regime, that issue is of equally significant national importance. This Court has held that "[t]he assumption that if respondents have no standing to sue, no one will have standing, is not a reason to find standing." *Valley Forge Christian College v. Americans United for Separation of Church and State*, 454 U.S. 464, 489 (1982) (quoting *Shlesinger v. Reservists Committee to Stop the War*, 418 U.S. 208, 227 (1974). But it would be truly anomalous if states may pass assisted suicide statutes stripping terminally ill persons of presumptions and protections against self harm and legal remedies for medical malpractice or misfeasance enjoyed by

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[5]*Cf. Roe v. Wade*, 410 U.S. 113 (1973) ("If this suggestion of personhood is established, the appellant's case [for a right to abortion], of course, collapses for the fetus' life would then be guaranteed specifically by the [Fourteenth] Amendment."). The freedoms listed protect against harm, and consent is neither a defense nor a relevant consideration. If the right to life is inalienable, then Measure 16 must be examined under strict scrutiny, although it does not even pass rational basis equal protection review.

others, yet no one could challenge those statutes. As developed more fully in the following section, the Ninth Circuit takes the untenable position that persons must be in the throes of suicidal depression and seeking assistance in killing themselves before bringing suit (an impossible situation), or tragic deaths must occur and actions be initiated by the estates of the deceased. The very depression that would make Elsner seek assisted suicide would keep her from filing a challenge to Measure 16 while in a suicidal depression. Absent psychiatric examination and notification of her next of kin (neither required by Measure 16), there would be no one to help her with her depression and represent her legal interests.[6] Under the Ninth Circuit's analysis, she will never get her day in court to challenge the statute which poses such a serious risk to her.

Standing should be sufficient where, as a result of the state official defendants' decision to recognize Measure 16 as constitutional and implement it by failing to enforce the penalties for violating the general ban on assisted suicide, Janice Elsner is in imminent and substantial peril for her life and stands currently stripped of protections and presumptions afforded others in Oregon. Tragedy should not be the ticket to constitutional review of Measure 16 — a review too late to help the victim of unwanted (but for suicidal depression) assisted suicide.

These are the issues raised by this case, and they are of vital national importance as the debate over assisted suicide continues. Because the settled practice of over two millennia and the lives of myriad vulnerable persons are at stake, state-sanctioned

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[6]The district court noted the absence of any court supervision of the assisted suicide process, although such supervision is required for non-terminally-ill persons who seek self-harm and are confined for extended treatment by mental health professionals. App. 46a.

death of innocent persons should not begin without the most careful review by this Court.

II. Janice Elsner is entitled to her day in court.

In Oregon, those not terminally ill enjoy a wide range of protections from self harm, assistance in suicide, and substandard medical care. These protections include a criminal statute barring assisted suicide,[7] a statute barring the use of consent as a defense to manslaughter (or any crime),[8] a statute authorizing use of reasonable force to prevent another from committing suicide or any self harm,[9] a statute authorizing civil commitment and evaluation by a mental health expert for those seeking suicide,[10] an objective and general standard of medical care with legal redress for medical malpractice not measuring up to the general and objective standard of patient care,[11] and care from physicians subject to discipline for not measuring up to objective and general medical standards.[12] As shall be seen, these protections are not available to the terminally ill under Measure 16, even if they have recurring bouts of suicidal depression.

By its general statutory scheme protecting people not terminally ill from self harm and assistance in suicide, Oregon has operated on the discovery of modern psychiatry that "sane

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[7]Or. Rev. Stat. § 163.125 (assisted suicide is second degree murder). By making it a crime, Oregon declares that assisted suicide "unjustifiably and inexcusably inflicts . . . substantial harm to individual [and] public interests." Or. Rev. Stat. § 161.025(1)(b).

[8]Or. Rev. Stat. § 163.117.

[9]Or. Rev. Stat. § 161.205.

[10]Or. Rev. Stat. § 426.070 et seq.

[11]Or. Rev. Stat. § 677.095.

[12]Or. Rev. Stat. § 677.190(1).

persons do not ordinarily kill themselves" and has asserted its interest in protecting people from self-harm caused by depression. *United States National Bank v. Underwriters at Lloyd's*, 396 P.2d 765, 770 (Or. 1964).

But the principle that persons who kill themselves almost always do so because of undiagnosed and untreated depression is also true of persons who are terminally ill. There is much evidence in the record to this effect, but it is also conveniently available to this Court in the briefs filed in *Washington v. Glucksberg* and *Vacco v. Quill*, presently awaiting this Court's decision. Because of the extensive material on suicidology presently in the Court's possession, there is little need educate the Court on this issue. A few examples will suffice.

The American Medical Association and the American Psychiatric Association agree that depression causes suicidal desire in terminally-ill patients — just as it does with non-terminally-ill persons:

> [d]epression is the single factor found to be a significant predictor of the desire for death. [citations omitted] In one study of 44 terminally ill patients, all but one of the eleven with "clinical depressive illness" expressed some wish for death, while none of the remaining 33 expressed such a wish. [citations omitted] In this regard, those with terminal or chronic illness are no different than others who express suicidal wishes. Most who commit suicide suffer from depression or some other diagnosable psychiatric illness, which is generally treatable. . . . [citations omitted].

Brief of the American Medical Association, the American Nurses Association, and the American Psychiatric Association, et al. as Amici Curiae in Support of Petitioners, *Quill v. Glucksberg*, No. 95-1858, at 9.

The American Suicide Foundation likewise agrees that depression causes suicidal desire among the terminally ill, just

as it does among those not terminally ill, so that terminally ill patients need protection from assisted suicide equal to that afforded those not terminally ill:

> No sound scientific or clinical basis exists for distinguishing suicidal patients with terminal conditions from other suicidal patients; treatable, reversible mental disorders, usually of a depressive nature, characterize both. Both groups are ambivalent about the desire to die; both suffer extreme anxiety and cognitive impairments; both have excessive needs for control, most dramatically expressed by controlling the time and place of their death. In both groups depression interferes with their decision-making ability.

Brief of the American Suicide Foundation, Amicus Curiae, Supporting Reversal, *Washington v. Glucksberg*, No. 96-110, at 3.

Oregon refuses to assert its protective interests against self harm and assistance in suicide for persons who are terminally ill, even though both terminally and non-terminally persons seek suicide because of depressive illness and would cease seeking suicide if the depression were diagnosed and treated. This constitutes discrimination on the basis of unscientific stereotypes and misinformation, demonstrating a lack of any rational basis for Measure 16. *Cf. Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432 (1985) (striking down a zoning ordinance excluding groups homes for persons with mental retardation on the basis of unscientific stereotypes of such persons).

Because of Measure 16, a person wishing to kill herself will be presumed to be making a reasonable request if she is terminally ill. There will be no general criminal ban to discourage physicians from helping her kill herself. A physician will be able to assert consent as a defense to what formerly constituted homicide. There will be no forceful intervention to prevent self harm. There will be no involuntary civil commitment for expert

evaluation — on the sole basis that a person has sought to harm herself. And what evaluation there is under Measure 16 will not be by a mental health professional, but by a primary care physician. This ignores the fact agreed upon by the American Medical Association and the American Psychiatric Association, that "most physicians fail to recognize depression, thereby precluding the opportunity for effective treatment. [citations omitted.]" Brief of the American Medical Association, the American Nurses Association, and the American Psychiatric Association, et al. as Amici Curiae in Support of Petitioners, *Quill v. Glucksberg*, No. 95-1858, at 9.

In fact, Patricia Wesley, M.D., a psychiatrist and neurologist teaching in the Department of Psychiatry at Yale, declared in an affidavit made a part of the record of this case that probably only psychiatrists could make the difficult diagnosis of depression in terminally patients (who often have depression-like symptoms, such as sleep and appetite disturbance, as a result of their terminal illness or treatment):

> [I]t is not an easy task to diagnose either psychiatric illness or suicidality, and . . . such tasks are probably beyond the expertise of most non-psychiatric physicians. Nonetheless, [Measure 16] asks just such busy, front-line, untrained physicians to perform this vital screening function. It will inevitably be done poorly, and many whose wish to die is based on psychiatric disturbance will be aided in killing themselves.

Affidavit of Patricia Wesley, M.D. at ¶ 27.

And at the time that the lethal prescription is actually taken — days, weeks, or months later — there is no evaluation by *anyone* under Oregon's state-imposed scheme.

Moreover, the physician assisting in suicide under Measure 16, need only meet a "good faith," subjective standard of care, not the general, objective standard of care required of all other

medical diagnosis and treatment.[13] This lowered *good faith* standard of care applies to the requisite diagnoses of whether a person is terminally ill and whether she is mentally "capable" as well as the provision of the prescription intended to be lethal (but which might actually leave the patient badly damaged and in a coma). The Oregon Supreme Court has rejected a lowered, good faith, standard of care for Oregon citizens, but Measure 16 strips terminally ill patients of the legal protections and the legal redress afforded those not terminally ill. *Rogers v. Meridian Park Hospital*, 307 Or. 612, 772 P.2d 929 (Or. 1989) (en banc) (rejecting good faith standard). They are assigned a badge of inferiority as second-class citizens.

In addition, Measure 16 does not even require the notification of the family of the person seeking assistance in suicide — or even a legally appointed guardian — so that there is no natural defender to intervene and protect the person whom the experts say is most likely suffering from undiagnosed and untreated suicidal depression. Measure 16, § 3.05.

As a result, Janice Elsner stands presently stripped of the protections against self harm and assisted suicide enjoyed by other Oregon residents. She does not have the same standard of medical care and the same legal redress afforded Oregon residents who are not terminally ill if her recurring suicidal depression causes her to seek self-harm.

This puts Janice Elsner at imminent and substantial risk of unwanted death. She is imminently dying from progressive muscular dystrophy. App. 59a. As the trial court found, she has

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[13]Measure 16, § 4.01 (emphasis added): "No person shall be subject to civil or criminal liability or professional disciplinary action for participating in *good faith* compliance with this Act. . . . No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating . . . in *good faith* compliance with this Act."

a history of recurring "clinical depression that result[s] in ambivalence about whether she want[s] to continue living." App. 59a-60a.[14] Her "medical histor[y] indicate[s she is] likely to become depressed and unable to control the timing or severity of that depression." App. 60a. "There is significant evidence in the record that depression is a major cause of suicide and is many times undiagnosed." *Id.* Because of Janice Elsner's recurring bouts with suicidal depression, if Oregon's scheme of state-authorized assisted suicide for terminally-ill persons is permitted to go into effect, she is at imminent and substantial risk of death because Oregon's scheme has inadequate safeguards to protect her.

Not only is this imminent life-and-death peril to Janice Elsner of immense concern in itself, but it also indicates that she has standing. Just as prison inmates need not prove that a fire is imminent to have standing, but may challenge prison conditions solely on the basis of an increased risk of fire, so Janice need not prove that she is about to commit suicide, only that she is at imminent and substantial risk for death because of Measure 16 and factors beyond her control. *DiMarzo v. Cahill*, 575 F.2d 15, 18 (1st Cir. 1978), *cert. denied* 439 U.S. 927 (1978). Moreover, as noted above, she already stands stripped of protections from and presumptions about assisted suicide afforded other Oregon residents simply because she is terminally ill, without any consideration of whether she is about to kill herself or not. She should have her day in court to make her case that Measure 16 has denied her the equal protection of the laws and placed her at imminent and substantial risk for unwanted death.

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[14] *Id.* "[A]mbivalence . . . **1:** simultaneous and contradictory attitudes or feelings (as attraction and repulsion) toward an object, person, or action **2 a:** continual fluctuation (as between one thing and its opposite) **b:** uncertainty as to which approach to follow . . . ." *Webster's Ninth New Collegiate Dictionary* at 77 (1985).

What has been said above is sufficient to demonstrate that the Ninth Circuit decision was erroneous with respect to the standing of Janice Elsner. However, it is important to deal specifically with the holding of the Ninth Circuit as to Janice Elsner's standing.

The trial court devoted an entire, separate opinion to discussing the standing issue, carefully establishing who had standing and why. App. 56a. The Ninth Circuit dismissed the standing of Elsner as too speculative. App. 11a-12a. The appellate court decided that for Janice Elsner to "take her life against her true intent"

> the following chain of events would have to occur: (1) Elsner . . . becomes clinically depressed to the point of being unable to make an informed decision to take her own life . . . ; (2) she makes an oral and written request for life-ending medication . . . ; (3) her attending and consulting physicians, neither of whom are required to be a psychologist or psychiatrist . . . , both misdiagnose her as being capable of making an informed decision . . . ; (4) both of the witnesses to her written request will fail to recognize . . . that she is incapable of making an informed decision . . . ; (5) fifteen days after her initial oral request she will still be suffering from severe clinical depression . . . and will make a renewed request to end her life . . . ; (6) immediately prior to writing a prescription for life-ending medication her attending physician will once again misdiagnose her as having made an informed decision . . . ; and (7) after receiving the life-ending medication she will take her own life against her true wishes.

App. 11a-12a.

While the Ninth Circuit has strung out a seven-link chain to demonstrate its claim that Janice Elsner's standing is "conjectural or hypothetical," instead of "actual and imminent," as the

district court found, seven links are too many for the facts and logic to support.

Link 1 is whether Janice would "become[] clinically depressed to the point of being unable to make an informed decision to take her own life." Janice has a history of recurring bouts with clinical depression, which were found likely to recur by the fact finder and during which she has suicidal desires. App. 59a-60a. Thus, where one need only demonstrate "an individualized showing that there is a very significant probability that the future harm will ensue," Janice easily meets this test, and the first link becomes a given. App. 9a.

The Ninth Circuit erroneously took no notice of this factual finding by the trial court in its standing analysis, which of itself shifts her standing from hypothetical to imminent. The facts (1) that she is not at the moment clinically depressed and ambivalent about suicide and life, but (2) that she has recurring bouts with clinical depression, and (3) that while she is clinically depressed she is incapable of bringing suit, fits her in a standing category akin to the classic category of issues capable of repetition yet evading review that require a unique rule for justice to be done. *Roe v. Wade*, 410 U.S. 113, 125 (1973).[15] In fact, Eric Dutson, a terminally-ill plaintiff with recurring clinical depression has already died while this case was in progress, presenting a classic version of the doctrine. App. 7a & n.1, 59-60a.

Links 3, 4, and 6 actually constitute one link, for all relate to the inability of individuals who are not trained health care experts to make the difficult diagnosis of depression in a person

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[15]Of course, she always stands presently devoid of presumptions about and protections from assisted suicide possessed by non-terminally ill persons and burdened with a lower standard of care if she should even consider assisted suicide with her medical care providers as a result of her recurrent depression.

who is terminally ill. If person who is not a health care professional cannot accurately diagnose psychological and psychiatric illnesses, multiple exposures to the non-experts do not improve on that inability. This link is highly likely, not speculative, because there is considerable evidence in the record that even physicians (not to mention the lay witnesses) regularly miss diagnoses of depression in terminally ill persons.[16] Therefore, this is a given, not a speculative link.

Links 2, 5, and 7 relate to the fact of a suicidal person actually pursuing and implementing assisted suicide without depression having abated in 15 days. As the evidence in the record shows, suicidal depression does not abate in the short span of 15 days, particularly if undiagnosed and untreated, nor less in the 48 hours required between the patient's written request and the writing of the lethal prescription. The trial court reviewed the evidence and found that "[t]he possibility that a judgment impairing disorder will resolve itself within this short time frame is unlikely." App. 38a-39a. Therefore, the idea that a suicidally depressed person would still be seeking suicide in fifteen days is a given, not a speculative link.

As to whether clinically depressed persons with suicidal desires (such as Janice Elsner) actually seek suicide assistance and kill themselves — the other topic of links 2, 5, and 7 — that, too, is a given. Links 2, 5, and 7 are really the same link repeated three times, i.e., do people who want suicide actually pursue it to completion over multiple occasions and multiple

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[16]As noted *supra*, the American Medical Association and the American Psychiatric Association agree that "most physicians fail to recognize depression, thereby precluding the opportunity for effective treatment. [citations omitted]." Brief of the American Medical Association, the American Nurses Association, and the American Psychiatric Association, et al. as Amici Curiae in Support of Petitioners, *Quill v. Glucksberg*, No. 95-1858, at 9. Many such authorities and several affidavits were provided to the trial court, which items will be available for review if certiorari is granted.

obstacles? One could posit 15 obstacles instead of three, but it would not lengthen the logical chain beyond one link, for it all boils down to whether people really pursue and commit suicide. The answer is self-evident or there would be no debate over assisted suicide. People really do this — and they pursue suicide over multiple days and obstacles until they succeed or their depression is diagnosed and treated.

Thus, the seven link chain reduces analytically to the following series of givens and a question:

- given that Janice has recurring bouts of clinical depression, which causes her suicidal desires;
- given that suicidal depression does not abate (especially without diagnosis and treatment) in less than 15 days; and
- given that people who are not mental health professionals cannot diagnose depression in terminally ill persons, so Janice's suicidal depression would likely go undiagnosed and untreated by primary-care physicians if she asked for assistance in killing herself;
- is Janice's recurring suicidal depression serious enough (or will it become serious enough) that she would really commit assisted suicide?

Would Janice seek suicide and assistance in doing so? If she would, she would pursue it through multiple occasions and obstacles, just as others do. But finding out if she would actually reach this stage, to which she is so close, is the very thing which Janice seeks to avoid.

Can it really defeat her claim (that she is at imminent and substantial risk for suicide due to suicidal depression and the easy implementation under Measure 16) for the Ninth Circuit to say "I bet she won't do it," so that she has no standing to challenge the statute? That's what it comes down to. The district court said the risk is too great that she will; the Ninth Circuit said the risk is too small that she will.

But the district court considered her recurring bouts with clinical depression in its analysis, and the Ninth Circuit did not. And the Ninth Circuit rejected her standing claim on the basis of a 7-link chain which really boils down to a series of givens and a question posing an individualized and high probability of risk of unwanted death for Janice Elsner. Her recurring clinical depression indicates a substantial risk that the answer is "yes."

But that is the question Janice wishes to avoid answering definitively because it is her life at stake. It is the reason she brought this suit. Her risk is imminent and substantial enough that she should not have to risk more to have it answered.

The real core of the Ninth Circuit's analysis is evident in its opinion shortly after the "chain" discussion. The Ninth Circuit said that a finding of standing could not be based on "probability merely in terms of quantitative percentages," but the plaintiff must show "an *individualized* showing that there is a very significant probability that the future harm will ensue. . . . We are not convinced that Elsner has made such an individualized showing." App. 9a.

But "a very significant probability" of individualized harm is exactly what Elsner has shown in two ways. First, if Measure 16 goes into effect, she would stand presently stripped of presumptions about and protections from assisted suicide which all non-terminally ill Oregon residents enjoy. No probability is involved. That part already exists.

Second, because she stands stripped of the standard of care and the legal redress afforded non-terminally ill Oregon residents, she is at imminent and substantial risk of death, i.e., "a very significant probability" because of her recurring clinical depression.

Janice Elsner's standing is readily apparent, provided one's view is not blocked by excess manufactured chain links. It is "actual and imminent," not "conjectural and hypothetical."

In sum, Janice Elsner's recurring suicidal depression distinguishes her from the possible choke-hold victim upon which the Ninth Circuit relied to deny her standing. App. 13a. She fits exactly the "systematic pattern repetition" that the Ninth Circuit said gives standing. App. 14a. The Ninth Circuit's notion that Elsner's chance of dying under Measure 16 is so speculative as to be "as applicable to every individual in the State of Oregon" cannot be taken seriously. App. 14a.

Janice Elsner's standing was well established in the district court's opinion and has been expanded upon here. In addition, several cases further demonstrate that Janice's present challenge is well within the mainstream of conventional standing law because Oregon has stigmatized the class of terminally-ill persons on the basis of archaic, stereotypical, and unscientific notions about why persons seek suicide.

In a unanimous opinion in *Heckler v. Mathews*, 465 U.S. 728 (1984), this Court acknowledged that "discrimination itself, by perpetuating 'archaic and stereotypic notions' or by stigmatizing members of the disfavored groups as 'innately inferior' and therefore as less worthy . . . can cause serious noneconomic injuries to those persons who are personally denied equal treatment solely because of their membership in the disfavored group." 465 U.S. at 739-40.

In a subsequent opinion, this Court explained that such "stigmatic injury" is cognizable for purposes of standing (i.e., it is "distinct and palpable" and "individualized") if the claimant is "personally subject to discriminatory treatment." *Allen v. Wright*, 468 U.S. 737, 757 n.22 (1984).

In *Northeastern Florida Contractors v. Jacksonville*, ___ U.S. ___, 113 S. Ct. 2297 (1993), this Court held that "an allegation that some discriminatory classification prevented the plaintiff from competing on an equal footing in its quest for a benefit" stated an "injury in fact" sufficient to establish standing. 113 S. Ct. at 2304. According to the Court,

> When the government erects a barrier that makes it more difficult for members of one group to obtain a benefit than it is for members of another group, a member of the former group seeking to challenge the barrier need not allege that he would have obtained the benefit but for the barrier in order to establish standing. The "injury in fact" in an equal protection case of this variety is the denial of equal treatment resulting from the imposition of the barrier, not the ultimate inability to obtain the benefit. . . . And in the context of a challenge to a set-aside program, the "injury in fact" is the inability to compete on an equal footing in the bidding process, not the loss of a contract.

113 S. Ct. at 2303. The Court went on to observe that

> It follows from the definition of "injury in fact" that petitioner has sufficiently alleged both that the city's ordinance is the "cause" of its injury and that a judicial decree directing the city to discontinue its program would "redress" the injury.

113 S. Ct. 2303 n. 5. Thus, all the elements of standing would be satisfied in such a case.

In the present case, persons with terminal conditions as defined by Measure 16 have standing to challenge the Act because they are personally subjected to discrimination solely because of their terminal condition. Measure 16 places "'them in a position of . . . inequality *vis-a-vis*'" similarly situated non-terminally-ill individuals with respect to their interest in receiving the benefits of the suicide protections of other Oregon laws. *Heckler v. Mathews*, 465 U.S. at 738 n.4 (quoting *Baker v. Carr*, 369 U.S. 186, 207 (1962). As a direct result of Measure 16, terminally-ill persons will not be provided the same levels of protection against suicide and suicide assistance otherwise provided to all other Oregon citizens. These protections include the deterrent effect created by the criminal

ban on assisting suicide and the stringent standard of care imposed generally on physicians. Moreover, the disparity in levels of protection will directly perpetuate the stigmatizing belief that terminally-ill persons are less worthy of protection, and directly expose them to the increased risk of depression-induced suicide.

Just as the claim raised in *Northeastern Florida Contractors* sufficiently alleged an injury in fact irrespective of whether the plaintiffs would ever experience an actual loss of the benefit of the city contract, the claim raised by terminally-ill persons at bar states an injury in fact irrespective of whether they will ever take their lives by suicide against their true intent. The essence of their injury lies in the unequal treatment that denies them the same benefits of the homicide code and civil protections provided to non-terminally-ill individuals. This injury will be inflicted the moment that Measure 16 becomes law. Thus, the district court was correct in finding that "Measure 16 implements a significantly lesser standard of care on physicians" and that "[t]his, itself, would confer standing on these plaintiffs." App. 61a.

Several additional cases provide helpful precedent. In *Neighborhood Action Coalition v. Canton*, 882 F.2d 1202 (6th Cir. 1989), the court found standing (under Title VI, which requires at a minimum Article III standing) by parties who

> allege that the City, as a result of a discriminatory animus, provides municipal services and federal funds to a racially identifiable neighborhood in a substantially inferior quality and quantity than the services provided to other areas of Canton. As a result of such actions, appellants claim that they have been injured by experiencing *little or no police response to their calls* . . . . Such injuries, if proven, are personal injuries . . . , are arguably traceable to the City's alleged racial policy, and could be addressed by a judicial order enjoining any

> racially disparate . . . providing of services. Therefore, the appellants have standing to sue in their own right.

882 F. 2d at 1017 (emphasis added). Similarly, Measure 16 directs state authorities to withhold from terminally-ill persons the protections that they provide to non-terminally-ill persons. *See also City of Davis v. Coleman*, 521 F.2d 661, 671 (9th Cir. 1975) (As failure to prepare an environmental impact statement was an injury in fact because it created "a risk that serious environmental impacts will be overlooked," so Measure 16's inferior suicide prevention services for terminally-ill persons increase the risk that suicidal depression will be overlooked.); *Smith v. City of Cleveland Heights*, 760 F.2d 720, 722-24 (6th Cir. 1985) (As a black resident not personally steered away from living in the city by city policy had standing to challenge the city steering policy because it stigmatized him, so terminally-ill persons have standing to challenge Measure 16 for stigmatizing them with second-class standards, even though Measure 16 is ostensibly directed towards persons with terminal conditions who truly desire to end their lives.).

III. Dr. Gary Lee and the other health care providers are entitled to their day in court.

The Ninth Circuit decided that none of the health care providers had standing. In doing so, the panel overlooked or ignored key matters.

A. *In deciding that the health care providers have no standing, the Ninth Circuit overlooked criminal and malpractice liability for noncompliance with Measure 16.*

The Ninth Circuit held that the health care plaintiffs "lack standing to bring this [forced participation] claim because Measure 16 does not provide for any penalty, criminal or otherwise, for violations of the challenged provisions." App. 18a. In so doing, the panel overlooked the fact that the health

care plaintiffs would be subject to malpractice liability, Or. Rev. Stat. § 677.095 (objective duty of care imposed), and, under Measure 16, to criminal liability. Measure 16 provides:

> The penalties in ORS 127.800 to 127.897 [Measure 16] do not preclude criminal penalties applicable under other law for conduct which is inconsistent with the provisions of ORS 127.800 to 127.897.

§ 4.02(4); Or. Rev. Stat. § 127.890(4).

Measure 16 thus specifically contemplates criminal liability for conduct inconsistent with it, even if the Measure itself neither contains a specific penalty for, nor specifically classifies, such conduct.

Moreover, Or. Rev. Stat. § 161.555(3) provides:

> An offense defined by a statute of this state, but without specification as to its classification or as to the penalty authorized upon conviction, shall be considered a Class A misdemeanor.

A Class A misdemeanor may be punished by up to one year in prison, Or. Rev. Stat. § 161.615(1), and/or up to a $5,000 fine. Or. Rev. Stat. § 161.635(a).[17]

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[17]A possible objection needs to be dealt with in advance. Oregon law provides that "[a]n offense is conduct for which a sentence to a term of imprisonment or a fine is provided by any law of this state or by any law or ordinance or a political subdivision of this state. An offense is either a crime or a violation or an infraction." Or. Rev. Stat. § 161.505. Thus, it might be argued that since conduct by health care providers inconsistent with Measure 16 is not specifically penalized, it is not an "offense" -- and therefore does not fall within the purview of Or. Rev. Stat. § 161.555(3), which employs the word "offense" as its operative term. Such an argument fails, however, both because it is circular and because it would render Or. Rev. Stat. § 161.155(3) meaningless: the provisions of Or. Rev. Stat. § 161.155(3) were specifically included in Oregon law to provide for penalties for conduct not otherwise penalized by imprisonment or fine under Oregon law.

The Ninth Circuit erred because, even apart from medical malpractice liability, it overlooked the fact that the health care plaintiffs would be subject to criminal liability for failure to conform to the requirements of Measure 16. The panel determined that such "an asserted injury would probably be sufficiently 'imminent' for purposes of standing," citing case law that says one need not "risk arrest or prosecution in order to have standing to challenge the constitutionality of a criminal statute." App. 19a (citation omitted). Under the threat of criminal prosecution for failure to comply with Measure 16, the health care providers have standing.

B. ***In deciding the case of health care providers is not ripe, the Ninth Circuit has overlooked criminal and malpractice liability for noncompliance with Measure 16.***

With respect to the health care plaintiffs, the same risk of criminal and malpractice liability mentioned in the preceding section was also overlooked by the panel when it determined that the plaintiffs' claim was not ripe because they faced, "at worst, . . . a civil enforcement action." App. 19a.

C. ***Because the terminally ill patients have standing, the health care provider plaintiffs ought to be able to assert jus tertii standing for their terminally ill patients with a history of depression.***

If, as argued, persons such as Elsner have standing, then the health care providers ought to be able to assert the interests of their patients suffering the same asserted injury as Elsner. App. 14a-15a.

D. ***In deciding that the health care provider plaintiffs have no standing because Measure 16 itself did not require informed consent dialogues, the panel overlooked the fact that the duty, regardless of its source, created an imminent, concrete, and particularized injury.***

The panel concluded that one reason the health care provider plaintiffs would not have standing is because their duty to advise patients of the Measure 16 option in informed consent dialogues (which would violate religious liberty rights) arises under existing Oregon statutes (prescribing informed consent), not Measure 16. App. 17a n.6. The panel has ignored the fact that if Measure 16 did not exist there would be no problem, but because it exists these plaintiffs have an imminent, concrete, and particularized injury, i.e., the moment Measure 16 goes into effect they must provide information to patients about assisted suicide in violation of their religious liberty rights. The panel overlooked these facts when it stated that "[b]ecause this challenge is directed at the informed consent requirements of state and federal law, and does not go to the validity of Measure 16 itself, we do not consider this claim." *Id.* The panel has confused a cause of action with the imminent injury which gives standing. The plaintiffs suffer an imminent injury because of Measure 16, which gives them standing even though Measure 16 does not itself require the informed consent.

E. *In opining that plaintiffs probably would not meet the causation and redressability elements of standing, the Ninth Circuit misapprehended the fact that both clearly exist.*

The panel overlooked the presence of causation and redressability, stating its doubt that these necessary elements of standing also existed. App. 15a-16a & n.3. For example, Elsner has several injuries from an unenjoined Measure 16, including a lowered standard of care. This injury would be caused by these officials ignoring the unconstitutional discrimination of Measure 16 and implementing Measure 16 by failing to enforce the existing criminal ban and professional disciplinary ban on assisted suicide. Similarly, this problem would be redressed by an injunction, as the district court's injunction has redressed it to date. This is true of all the petitioners before this Court.

CONCLUSION

The question of who has standing to challenge a regime of assisted suicide with lower standards of care imposed on terminally-ill persons is one of immense public importance. If the Ninth Circuit decision stands, dying persons troubled with recurring suicidal desires, such as Janice Elsner, will be deprived of the assurance that their lives are as valued and protected as those not terminally ill. They will be at actual and imminent risk for unwanted death. They will be required to remain in a second-class citizen classification based on unscientific stereotypes and will remain stripped of protections afforded other citizens. Janice should get her day in court to challenge these injustices.

If the Ninth Circuit panel's decision stands Dr. Gary Lee, Dr. William Petty, Sister Geraldine Bernards, Fritz Beck, June Beck, and two residential care facilities will be forced into instant accommodation of, participation in, and association with an assisted suicide scheme which they oppose on grounds of conscience. For those with religious objections, this will violate their right to free exercise of religion. These health care providers should get their day in court to protect their rights.

The Ninth Circuit panel's analysis is flawed in foundation and superstructure. This petition should be granted.

Respectfully submitted,

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May 1997

APPENDIX

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FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

GARY LEE, M.D. individually and on behalf of his patients; WILLIAM PETTY, M.D., individually and on behalf of his patients; ERIC DUTSON, individually and as co-representative of a class of persons who have the disability of a terminal disease even with medical treatment; JANICE ELSNER, individually and as co-representative of a class of persons who have the disability of a terminal disease even with medical treatment; CLAUDINE STOTLER, individually and as a representative of a sub-class of person who have the disability of a terminal disease even with medical treatment and who are being, or will be treated at the Oregon Health Sciences University Hospital; JEFFREY M. WEINKAUF, individually and as a representative of a class of Oregon patients who have a possibly terminal disease absent medical treatment; FRITZ BECK; JUNE BECK; THE WILLOWS HOME, INC.; SISTER GERALDINE BERNARDS, individually and as Administrator of Maryville Nursing Home, Inc.; and MARYVILLE NURSING HOME, INC.,

Plaintiffs-Appellees-Cross-Appellants

v.

Nos. 95-35804
95-35805
95-35854
95-35948
95-35949

D.C. No.
CV-94-06467-MRH

ORDER AMENDING OPINION AND AMENDED OPINION

STATE OF OREGON; DOUGLAS F. HARCLEROAD, in his official capacity as the District Attorney for Lane County, Oregon, and as a representative of the class of all district attorneys in the State of Oregon; JOHN KITZHABER, in his official capacity as Governor of Oregon; TERRY L. CONNOR, D.O., in his official capacity as Chairman of the Oregon Board of Medical Examiners; EDWARD A. HEUSCH, D.O., in his official capacity as Vice-chairman of the Oregon Board of Medical Examiners; CATHERINE M. NATER, in her official capacity as Secretary of the Oregon Board of Medical Examiners; JOHN W. GRIGSBY, M.D., in his official capacity as a member of the Oregon Board of Medical Examiners; SARAH S. HENDRICKSON, M.D., in her official capacity as a member of the Oregon Board of Medical Examiners; GEORGE A. PORTER, M.D., in his official capacity as a member of the Oregon Board of Medical Examiners; JAMES H. SAMPSON, M.D., in his official capacity as a member of the Oregon Board of Medical Examiners; ROSEMARY C. LEE SELINGER, M.D., in her official capacity as a member of the Oregon Board of Medical Examiners; FRED R. STARK, M.D., in his official capacity as a member of the Oregon Board of Medical Examiners; MARALYN E. TURNER, in her official

capacity as a member of the Oregon Board of Medical Examiners; J. BRUCE WILLIAMS, M.D., in his official capacity as a member of the Oregon Board of Medical Examiners; PETER KOHLER, in his official capacity as the President of the Oregon Health Sciences University; LEE SWANSON, JR., HERBERT ASCHKENASY, ROBERT L.R. BAILEY, DIANE CHRISTOPHER, BOBBY LEE, WALTER R. MILLER, ESTHER PUENTES, GEORGE E. RICHARDSON, JR., RONDA L. TROTMAN REESE, JIM WILLIS, and JANICE J. WILSON, in their official capacities as members of the Oregon State Board of Higher Education; and OREGON HEALTH SCIENCES UNIVERSITY HOSPITAL,

Defendants-Appellants-Cross-Appellees,

and

PETER GOODWIN; BARBARA COOMBS LEE; ELVEN SINNARD; MICHAEL VERNON; TED LEVIN; and TIM SCHUCK,

Intervenors-Appellees-Cross-Appellees.

Appeals from the United States District Court
for the District of Oregon
Michael R. Hogan, District Judge, Presiding

Argued and Submitted
July 9, 1996—Portland, Oregon

Filed February 27, 1997
Amended March 21, 1997
Amended April 16, 1997

Before: Alfred T. Goodwin and Melvin Brunetti, Circuit Judges, and Samuel P. King,* District Judge.

Opinion by Judge Brunetti

[summary omitted; not an official part of decision]

COUNSEL

Thomas O. Alderman, Eugene, Oregon; James Bopp, Jr., Richard E. Coleson, Bopp, Coleson and Bostrom, Terre, Haute, Indiana, for the plaintiffs-appellees-cross-appellants.

Eli Stutsman, Portland, Oregon; Charles F. Hinkle, Stoel, Rives, Boley, Jones & Grey, Portland, Oregon; Thomas M. Christ, ACLU Foundation of Oregon, Inc., Portland, Oregon, for the intervenors-appellees-cross- appellees.

Thomas A. Balmer, Deputy Attorney General, Salem, Oregon for the defendants-appellants-cross-appellees.

ORDER

The opinion amended March 21, 1997, is amended as follows:

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*Hon. Samuel P. King, Senior United States District Judge for the District of Hawaii, sitting by designation.

Slip Opinion page 3099, in the first paragraph of "A. The Proceedings" the first sentence is deleted. The following sentence is inserted in its place: "On November 8, 1994, through the initiative power reserved them under the Oregon Constitution, Oregon voters approved Measure 16, the Oregon Death With Dignity Act ("Measure 16" or "the Act")."

OPINION

BRUNETTI, Circuit Judge:

The plaintiffs in this case are doctors, patients, and residential care facilities challenging the facial validity of the State of Oregon's Death With Dignity Act. Plaintiffs contend the Act violates the First and Fourteenth Amendments to the United States Constitution, as well as several federal statutes. The district court found the Act to violate the Equal Protection Clause and permanently enjoined its enforcement. Because the federal courts do not have jurisdiction to entertain Plaintiffs' claims, we vacate and remand with instructions to dismiss Plaintiffs' complaint.

BACKGROUND

A. The Proceedings

On November 8, 1994, through the initiative power reserved them under the Oregon Constitution, Oregon voters approved Measure 16, the Oregon Death With Dignity Act ("Measure 16" or "the Act"). Measure 16, reprinted in full as an Appendix to this opinion, establishes a statutory framework within which a competent terminally-ill adult may legally request a prescription for medication "for the purpose of ending his or her life in a humane and dignified manner." Measure 16, § 2.01. Fifteen

days before the Act was to take effect, on November 23, 1994, Plaintiffs filed a class action complaint alleging the Act violated their equal protection and due process rights under the Fourteenth Amendment, their free exercise of religion and freedom of association rights under the First Amendment, and their statutory rights under the Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101 *et seq.*, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 791 *et seq.*, and the Religious Freedom Restoration Act of 1993, 42 U.S.C. §§ 2000bb *et seq.*

After granting Plaintiffs preliminary injunctive relief preventing the Act from taking effect, *Lee v. State of Oregon,* 869 F.Supp. 1491 (D.Or. 1994) (order granting preliminary injunction), the district court granted summary judgment for Plaintiffs on their equal protection claim and issued a permanent injunction against the Act's enforcement on August 3, 1995. *Lee v. State of Oregon*, 891 F.Supp. 1439 (D.Or. 1995) (declaratory judgment and permanent injunction); *Lee v. State of Oregon,* 891 F.Supp. 1429 (D.Or. 1995) (equal protection opinion). Essentially, the district court found that the Act violated the Equal Protection Clause because it provided insufficient safeguards to prevent against an incompetent (i.e. depressed) terminally-ill adult from committing suicide, thereby irrationally depriving terminally-ill adults of safeguards against suicide provided to adults who are not terminally ill. The district court did not address Plaintiffs' other claims for relief.

B. The Parties

1. Plaintiffs

In an opinion issued contemporaneously with its equal protection ruling, the district court determined that the only plaintiffs who have standing to assert an equal protection, due

process, Americans with Disabilities Act, or Rehabilitation Act challenge are: Eric Dutson[1] and Janice Elsner, two competent terminally-ill adults who have suffered from bouts of depression in the past, and Maryville Nursing Home and Willows Home, two residential care facilities. *Lee v. State of Oregon*, 891 F.Supp. 1421 (D.Or. 1995) (standing opinion). In a cross-appeal, Drs. Gary Lee and William Petty challenge the district court's finding that they did not have standing to assert equal protection and due process challenges on behalf of their patients. [Red 50-55; ER 91.] Additionally, Plaintiffs cross-appeal the district court's denial of their motion to certify a class consisting of all individuals in the State of Oregon who have a "terminal disease" as defined in Measure 16. *See* Measure 16, § 1.01(12) (defining "terminal disease" as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months").

As for Plaintiffs' First Amendment and Religious Freedom Restoration Act challenges, the district court determined that Dr. Petty, Maryville Nursing Home, Sister Geraldine Bernards as the administrator of Maryville Nursing Home, Willows Home, and Fritz and June Beck as the owners of Willows Home, all had standing to assert these claims.

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[1]Mr. Dutson died on July 2, 1995, a month before the district court entered judgment for plaintiffs and issued a permanent injunction. Apparently, however, Plaintiffs' counsel did not inform the district court of Dutson's death until August 8, 1995, five days after the entry of judgment. [See CR 193 (notification of Dutson death); CR 191, ER 98-99 (declaratory judgment and permanent injunction).]

2. Defendants

The district court determined that the only properly named defendants were: Douglas F. Harcleroad, District Attorney for Lane County, Oregon, and all eleven members of the Oregon State Board of Medical Examiners. The state of Oregon and the attorney general and governor of Oregon were dismissed on Eleventh Amendment immunity grounds. Additionally, the district court determined that several Oregon citizens could properly intervene as defendants pursuant to Federal Rule of Civil Procedure 24. Defendants appeal the district court's grant of summary judgment on Plaintiffs' equal protection claim and the denial of Defendants' motion for summary judgment on all of Plaintiffs' claims.

DISCUSSION

The judicial power of the United States, both provided and limited by Article III of the Constitution, "is not an unconditioned authority to determine the constitutionality of legislative or executive acts." *Valley Forge Christian College v. Americans United for Separation of Church and State Inc.*, 454 U.S. 464, 471 (1982). Rather, "[t]he power to declare the rights of individuals and to measure the authority of governments . . . 'is legitimate only in the last resort, and as a necessity in the determination of real, earnest and vital controversy.' " *Id.* (quoting *Chicago & Grand Trunk R. Co. v. Wellman*, 143 U.S. 339, 345 (1892)). In order to ensure that a federal court's Article III power has been properly invoked, the courts have developed several doctrines, including standing, mootness, and ripeness, each of which imposes a different requirement on the substance of a plaintiff's claim. *See Allen v. Wright*, 468 U.S. 737, 750 (1984). We are particularly concerned in this case with standing and ripeness.

The standing doctrine addresses the question of "whether the litigant is entitled to have the court decide the merits of the dispute." *Warth v. Seldin*, 422 U.S. 490, 498 (1975). At its core, the standing requirement has three "irreducible constitutional[ly] minimum " elements. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992).

> First, the plaintiff must have suffered an "injury in fact" — an invasion of a legally protected interest which is (a) concrete and particularized, and (b) actual or imminent, not conjectural or hypothetical. Second, there must be a causal connection between the injury and the conduct complained of — the injury has to be fairly traceable to the challenged action of the defendant, and not the result of the independent action of some third party not before the court. Third, it must be likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision.

Id. at 560-61 (citations, internal quotations and footnote omitted).

While standing is primarily concerned with *who* is a proper party to litigate a particular matter, ripeness addresses *when* that litigation may occur. *See* Erwin Chemerinsky, *Federal Jurisdiction* § 2.4, at 98-99 (1989). The "basic rationale" of the ripeness doctrine is "to prevent the courts, through avoidance of premature adjudication, from entangling themselves in abstract disagreements." *Abbott Laboratories v. Gardner*, 387 U.S. 136, 148 (1967). When a party is challenging the validity of a statute or regulation, the ripeness doctrine can be specifically understood "as involving the question of when may a party seek preenforcement review." Chemerinsky, § 2.4 at 100 (emphasis omitted). Whether a claim is ripe depends on "the fitness of the issues for judicial decision and the hardship to the

parties of withholding court consideration." *Abbott Laboratories*, 387 U.S. at 149; *see Freedom to Travel Campaign v. Newcomb*, 82 F.3d 1431, 1434 (9th Cir. 1996). Both standing and ripeness are jurisdictional issues reviewed *de novo*. *Wedges/Ledges of California, Inc. v. City of Phoenix*, 24 F.3d 56, 61 (9th Cir. 1994); *Southern Pac. Transp. Co. v. City of Los Angeles*, 922 F.2d 498, 502 (9th Cir. 1990), *cert. denied*, 502 U.S. 943 (1991).

A. Equal Protection, Due Process, Americans with Disabilities Act, and Rehabilitation Act Claims

The one remaining individual plaintiff held to have standing to assert Plaintiffs' equal protection, due process, Americans with Disabilities Act, and Rehabilitation Act claims is Janice Elsner. She has a progressive form of muscular dystrophy and has already lived longer than doctors expected. Although she has not been given a prognosis of less than six months to live, for purposes of analysis we will assume that she has a terminal disease within the meaning of Measure 16. In the past, Elsner has suffered clinical depression that resulted in ambivalence about whether she wanted to continue living. The threatened injury asserted by Elsner is the possibility that, utilizing the procedures established by Measure 16, she will take her own life against her true intent. For this injury to manifest itself, the following chain of events would have to occur: (1) Elsner (a) becomes clinically depressed to the point of being unable to make an informed decision to take her own life, or (b) is unduly influenced by a third party to take her own life; (2) she makes an oral and a written request for life-ending medication, *see* Measure 16, §§ 2.02, 3.06; (3) her attending and consulting physicians, neither of which are required to be a psychologist or psychiatrist under the Act, both misdiagnose her as being capable of making an informed decision, *see id.* §§ 3.01-3.04;

(4) both of the witnesses to her written request will fail to recognize (either intentionally or unintentionally) that she is incapable of making an informed decision or has been subject to undue influence, *see id.* § 2.02; (5) fifteen days after her initial oral request she will still be suffering from severe clinical depression or undue influence and will make a renewed request to end her life, *see id.* § 3.08; (6) immediately prior to writing a prescription for life-ending medication her attending physician will once again misdiagnose her as having made an informed decision, *see id.* § 3.04; and (7) after receiving the life-ending medication she will take her own life against her true wishes.

Despite this chain of speculative contingencies, the district court found the threatened injury to be "actual and imminent" rather than "conjectural or hypothetical." As argued by Plaintiffs-Appellees, standing exists

> because [t]he empirical facts reveal that the risk of harm to terminally ill patients is far from speculative: (1) persons with a terminal disease are at a greatly increased risk for depression; (2) depression carries with it a serious risk of becoming suicidal; and (3) primary care physicians regularly miss suicidal depression in their own patients.

Appellees' Brief, at 49.

Even if the record before the district court could support these "empirical facts," they are insufficient to confer standing on Elsner. First, as a matter of quantitative probability, the "facts" only indicate that terminally-ill adults are at a greater risk of depression than those who are not terminally ill, and do not demonstrate that a significant number of terminally-ill adults have depression severe enough to prevent them from making an informed decision. More importantly, we have previously stated

that our analysis on this issue "cannot be reduced to considering probability merely in terms of quantitative percentages," *Nelsen v. King County*, 895 F.2d 1248, 1250 (9th Cir. 1990), but must instead focus qualitatively on whether the plaintiff has made "an *individualized* showing that there is 'a very significant possibility' that the future harm will ensue." *Id.* (emphasis added) (quoting *Sample v. Johnson*, 771 F.2d 1335, 1343 (9th Cir. 1985)). We are convinced that Elsner has not made such an individualized showing.

Several precedents support our conclusion. In *City of Los Angeles v. Lyons*, 461 U.S. 95 (1983), the Supreme Court considered whether an individual who had been subjected to an unconstitutional chokehold by the Los Angeles police had standing to seek injunctive relief preventing the police from using the chokehold in the future. Despite the allegation that the Los Angeles police routinely applied chokeholds in situations when they were not threatened by the use of deadly force, *id.* at 105, and the acknowledgment of a possibility that someone in Los Angeles would be killed by the application of an unconstitutional chokehold, *id.* at 108, the Court found no standing because it was "no more than speculation to assert . . . that Lyons *himself* would again be subject to an unconstitutional chokehold. *Id.* (emphasis added).

Likewise, in *O'Shea v. Littleton*, 414 U.S. 488 (1974), the Court found a lack of standing when the plaintiffs would only be subjected to the alleged discriminatory and otherwise unconstitutional administration of criminal justice within a particular county if they proceeded to violate a law and were charged, held to answer, and tried in the county. The Court reasoned that "attempting to anticipate whether and when these respondents will be charged with crime and will be made to appear before either petitioner takes us into the area of specula

tion and conjecture," *id.* at 497, and held that such speculation and conjecture were insufficient to confer standing.

In our own circuit, we "have repeatedly found a lack of standing where the litigant's claim relies upon a chain of speculative contingencies." *Nelsen*, 895 F.2d at 1252. For example, in *Nelsen*, we held that individuals who had been detained in an alcohol treatment center did not have standing to seek injunctive relief challenging conditions of detention within the center because in order to suffer injury they would have to "remain within [the c]ounty, remain indigent, begin drinking uncontrollably several years after their discharge from the Center . . . commit an alcohol-related offense, be prosecuted for that offense, be convicted, be offered the choice to reenter the Center, make that choice, *and* find that the conditions at the Center were the same as they allegedly were [before]." *Id.* at 1252; *see also Eggar v. City of Livingston*, 40 F.3d 312, 317 (9th Cir. 1994) (claim of standing for injunctive relief against a judge for the unconstitutional denial of the right to counsel held too speculative when the plaintiffs would have to "commit future crimes in the City, be indigent, plead guilty, and be sentenced to jail"), *cert. denied*, ___ U.S. ___, 115 S.Ct. 2566 (1995); *Oregon State Police Officers Ass'n v. Peterson*, 979 F.2d 776, 778 (9th Cir. 1992) (union's claim of standing for injunctive relief against the Supreme Court of Oregon for the unconstitutional denial of attorneys fees in 42 U.S.C. § 1983 cases held too speculative when "a state or local government employer would have to violate both state and federal law; the violation would have to injure a member of the Union; the case would have to be reduced to judgment rather than settled; and the state court would have to rule in the Union's favor on the state issue but not reach the federal question or decide on both state and federal grounds"); Nelsen, 895 F.2d at 1253-54 (collecting cases). *See generally Nelsen*, 895 F.2d at 1254 (concluding that "[i]n those circumstances where we, or the

Supreme Court, have found standing to exist for a threat of future harm, it has consistently been determined that some systematic pattern repetition, or relationship exists").

The district court seemed to base its holding on two rationales — that there was a danger Elsner would only have standing after she was dead or close to death, and that if Elsner did not have standing, nobody would. The chance of Elsner dying according to the scenario presented is so speculative, however, that the first rationale is almost as applicable to every individual in the State of Oregon. Just because the asserted injury is the threat of death does not mean that the plaintiff is relieved from the requirement of asserting some significant possibility of injury. *See Lyons*, 461 U.S. at 108 (acknowledging that someone in the future may be killed by the unconstitutional application of a chokehold, but finding no standing because it was only speculation that the plaintiff would). As for the second rationale, the Supreme Court has held that "[t]he assumption that if respondents have no standing to sue, no one would have standing, is not a reason to find standing." *Valley Forge Christian College*, 454 U.S. at 489 (quoting *Schlesinger v. Reservists Committee to Stop the War*, 418 U.S. 208, 227 (1974)).

Nor would our analysis change if the named residential care facilities and doctors could assert these claims on behalf of their patients. *See Powers v. Ohio*, 499 U.S. 400, 411 (1991) (holding that a litigant may bring an action on behalf of a third party so long as: (1) the litigant has suffered an "injury in fact"; (2) the litigant has a close relation to the third party; and (3) there is some hindrance to the third party's ability to protect his or her own interests). At best, the doctors and residential care facilities would be asserting the interests of unnamed patients

who are no closer to suffering the asserted injury than Elsner.[2] Because these unnamed patients would not have standing to assert their own interests, their doctors and care-givers cannot have standing to assert interests on their behalf.

Lastly, the fact that Plaintiffs filed their complaint as a class action is of no moment. Standing "is a jurisdictional element that must be satisfied prior to class certification." *Nelsen*, 895 F.2d at 1249-50 (quoting *LaDuke v. Nelson*, 762 F.2d 1318, 1325 (9th Cir. 1985)). "If the litigant fails to establish standing, he may not 'seek relief on behalf of himself or any other member of the class.' " *Id.* at 1250 (quoting *O'Shea*, 414 U.S. at 494).

None of the Plaintiffs can assert an "injury in fact" resulting from the alleged equal protection, due process, Americans with Disabilities Act, or Rehabilitation Act violations. While we also doubt that Plaintiffs have met the other two constitutional requirements for standing — that there is a causal connection between the injury and the conduct complained of[3] and that the

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[2]We note that Elsner may not in fact have a "terminal disease" as defined in Measure 16, and may therefore not be able to invoke Measure 16's provisions in the first instance. However, precisely because of the possibility that the named doctors and residential care facilities could assert the interests of their terminally-ill patients, we assume that Elsner does have a "terminal disease" for purposes of the "injury in fact" analysis.

[3]The remaining named defendants are a district attorney responsible for the prosecution of Oregon's ban on assisted suicide and the board responsible for regulating the medical profession in Oregon. Elsner's injury, however, would result not only from the action (or inaction) of these defendants, but also from the independent actions of herself, her treating physician, the consulting physician, the witnesses to her written request, and possibly other individuals asserting undue influence on her decision-making process. It is doubtful, therefore, that the injury asserted by Elsner is "fairly traceable to the challenged action of the defendant, and not the result of the independent

injury will be redressed by a favorable decision[4] — we need not address these concerns. The failure to assert an "injury in fact" requires the dismissal of these claims.[5]

B. First Amendment and RFRA Claims

The district court found that Dr. William Petty, Maryville Nursing Home, Sister Geraldine Bernards as Maryville Nursing Home's administrator, Willows Home, and Fritz and June Beck as the owners of Willows Home all had standing to assert that they will be forced to carry out certain actions under Measure 16 in violation of their rights under the First Amendment and the Religious Freedom Restoration Act. These plaintiffs assert

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action of some third party not before the court." *Lujan*, 504 U.S. at 560.

[4]We express no opinion on the possibility of redress by future litigation. The decision of this court in *Compassion in Dying v. State of Washington*, 79 F.3d 790 (9th Cir. 1996) (en banc) is now pending before the Supreme Court, *cert. granted* ___ U.S. ___, 117 S.Ct. 37 (1996), and we need not and do not address any of the substantive questions that may be answered or dealt with in that case.

[5]At oral argument, Plaintiffs also argued that, in the case of terminally-ill patients, Measure 16 reduces the standard of care doctors owe their patients from objective reasonableness to subjective good faith. *Compare* O.R.S. § 677.095 ("A physician . . . has the duty to use that degree of care, skill, and diligence which is used by ordinarily careful physicians . . . in the same or similar circumstances. . . .") *with* Measure 16 § 4.01(1) ("No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with this Act."). This reduction, argue Plaintiffs, is itself an injury sufficient to confer standing.

We reject this argument because we find that, even were Plaintiffs correct in their interpretation of Measure 16, the mere reduction in the standard of care owed by doctors to their terminally-ill patients is insufficient to confer standing without an allegation that an individual patient has suffered or will imminently suffer some concrete and particularized injury as a result of the reduction in the standard of care.

two different types of injuries: First, all five of these plaintiffs assert that Measure 16 will force them to participate in the prescription of life-ending medication, either by being required to transfer the medical records of a patient who is seeking life-ending medication to another physician (Measure 16, § 4.01(4)), by being required to advise a patient of the option of Measure 16's procedures (*id.* § 3.01(2)), or (in the case of the residential care facilities) by being required to appoint a witness to a patient's written request for life-ending medication (*id.* § 2.02(4)).[6] Second, the residential care facilities and their administrators assert that Measure 16 will prevent them from excluding physicians who wish to prescribe life-ending medication to the facilities' residents. *See id.* § 4.01(2). These asserted injuries are appropriately analyzed separately.

1. Alleged Forced Participation

Plaintiffs assert that Measure 16 violates their First Amendment and RFRA rights by forcing them to participate in a patient's suicide in three separate ways. Assuming (without deciding) that Measure 16 does in fact require them to perform the asserted acts, their claim suffers from both standing and ripeness defects.

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[6]Plaintiffs also allege that, pursuant to other provisions of state and federal law, *see* 42 U.S.C. § 1395cc(f)(1)(A)(i) (requiring health care organizations to provide written information to patients concerning their "rights under State law . . . to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives"); O.R.S. § 677.097 (describing the procedure required under Oregon law to obtain the informed consent of a patient), they will be unconstitutionally forced to inform patients of the availability of Measure 16's procedures. Because the challenge is directed at the informed consent requirements of state and federal law, and does not go to the validity of Measure 16 iteself, we do not consider this claim.

Plaintiffs lack standing to bring this claim because Measure 16 does not provide for any penalty, criminal or otherwise, for a violation of the challenged provisions. *See* Measure 16 § 4.02 (providing criminal penalties only for forging a request and coercing a patient to make a request for life ending medication). Thus, while an asserted injury would probably be sufficiently "imminent" for purposes of standing, *see Babbitt v. United Farm Workers National Union,* 442 U.S. 289, 298-99 (1979) (holding that a plaintiff does not have to risk arrest or prosecution in order to have standing to challenge the constitutionality of a criminal statute), Plaintiffs have failed to allege a "concrete and particularized" injury in the first instance. *See Lujan*, 504 U.S. at 560 (stating that injury must be "concrete and particularized" *and* "actual or imminent"). Without such an injury, Plaintiffs lack standing.

For the same reason, this claim is not ripe. While the issues may be fit for judicial consideration because they are predominately legal ones that do not depend on a particular factual context, *see Newcomb,* 82 F.3d at 1434 (stating that "[l]egal questions that require little factual development are more likely to be ripe"), this claim is not ripe because Plaintiffs have not identified any hardship that would befall them if their claims were not considered at this time. *See Toilet Goods Ass'n v. Gardner,* 387 U.S. 158, 165 (1967) (dismissing claim on ripeness grounds because noncompliance with the challenged regulation "would at most lead only to a suspension of certification services to the particular party, a determination that can then be promptly challenged through an administrative procedure, which in turn is reviewable by a court") (footnote omitted). Noncompliance with the allegedly offending provisions of Measure 16 would lead, at worst, to a civil enforcement action, at which time the plaintiff doctors and health care organizations could more appropriately challenge the provisions' validity.

2. Alleged Forced Association With Those Who Do Participate

The residential care facilities and their administrators also assert that Measure 16 will prevent them from excluding physicians who wish to prescribe life-ending medication to the facilities' residents, in violation of their rights to freedom of association and freedom of religion. Because these plaintiffs have not alleged that there are in fact any doctors at their facilities who will participate in Measure 16's procedures, there is no "injury in fact" upon which to base standing.

CONCLUSION

The federal courts do not have Article III jurisdiction over Plaintiffs' claims. Accordingly, we vacate the judgment of the district court and remand with instructions to dismiss Plaintiffs' complaint for lack of jurisdiction.

VACATED AND REMANDED.

APPENDIX

THE OREGON DEATH WITH DIGNITY ACT

SECTION 1 GENERAL PROVISIONS

§ 1.01 DEFINITIONS

The following words and phrases, whenever used in this Act, shall have the following meanings:

(1) "Adult" means an individual who is 18 years of age or older.

(2) "Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.

(3) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.

(4) "Counseling" means a consultation between a state licensed psychiatrist or psychologist and a patient for the purpose of determining whether the patient is suffering from a psychiatric or psychological disorder, or depression causing impaired judgment.

(5) "Health care provider" means a person licensed, certified, or otherwise authorized or permitted by the law of this

State to administer health care in the ordinary course of business or practice of a profession, and includes a health care facility.

(6) "Incapable" means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, a patient lacks the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available. Capable means not incapable.

(7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an of the relevant facts and after being fully informed by the attending physician of:

(a) his or her medical diagnosis;

(b) his or her prognosis;

(c) the potential risks associated with taking the medication to be prescribed;

(d) the probable result of taking the medication to be prescribed;

(e) the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

(8) "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.

(9) "Patient" means a person who is under the care of a physician.

(10) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine by the Board of Medical Examiners for the State of Oregon.

(11) "Qualified patient" means a capable adult who is a resident of Oregon and has satisfied the requirements of this Act in order to obtain a prescription for medication to end his or her life in a humane and dignified manner.

(12) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months.

SECTION 2
WRITTEN REQUEST FOR MEDICATION TO END ONE'S LIFE IN A HUMANE AND DIGNIFIED MANNER

§ 2.01 WHO MAY INITIATE A WRITTEN REQUEST FOR MEDICATION

An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with this Act.

§ 2.02 FORM OF THE WRITTEN REQUEST

(1) A valid request for medication under this Act shall be in substantially the form described in Section 6 of this Act, signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request.

(2) One of the witnesses shall be a person who is not:

(a) A relative of the patient by blood, marriage or adoption;

(b) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or

(c) An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

(3) The patient's attending physician at the time the request is signed shall not be a witness.

(4) If the patient is a patient in a long term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having the qualifications specified by the Department of Human Resources by rule.

SECTION 3
SAFEGUARDS

§ 3.01 ATTENDING PHYSICIAN RESPONSIBILITIES

The attending physician shall:

(1) Make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily;

(2) Inform the patient of:

(a) his or her medical diagnosis;

(b) his or her prognosis;

(c) the potential risks associated with taking the medication to be prescribed;

(d) the probable result of taking the medication to be prescribed;

(e) the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

(3) Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily;

(4) Refer the patient for counseling if appropriate pursuant to Section 3.03;

(5) Request that the patient notify next of kin;

(6) Inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the end of the 15 day waiting period pursuant to Section 3.06;

(7) Verify, immediately prior to writing the prescription for medication under this Act, that the patient is making an informed decision:

(8) Fulfill the medical record documentation requirements of Section 3.09;

(9) Ensure that all appropriate steps are carried out in accordance with this Act prior to writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner.

§ 3.02 CONSULTING PHYSICIAN CONFIRMATION

Before a patient is qualified under this Act, a consulting physician shall examine the patient and his or her relevant medical records and confirm, in writing, the attending physician's diagnosis that the patient is suffering from a terminal disease, and verify that the patient is capable, is acting voluntarily and has made an informed decision.

§ 3.03 COUNSELING REFERRAL

If in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder, or depression causing impaired judgment, either physician shall refer the patient for counseling. No

medication to end a patient's life in a humane and dignified manner shall be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder, or depression causing impaired judgment.

§ 3.04 INFORMED DECISION

No person shall receive a prescription for medication to end his or her life in a humane and dignified manner unless he or she has made an informed decision as defined in Section 1.01(7). Immediately prior to writing a prescription for medication under this Act, the attending physician shall verify that the patient is making an informed decision.

§ 3.05 FAMILY NOTIFICATION

The attending physician shall ask the patient to notify next of kin of his or her request for medication pursuant to this Act. A patient who declines or is unable to notify next of kin shall not have his or her request denied for that reason.

§ 3.06 WRITTEN AND ORAL REQUESTS

In order to receive a prescription for medication to end his or her life in a humane and dignified manner, a qualified patient shall have made an oral request and a written request, and reiterate the oral request to his or her attending physician no less than fifteen (15) days after making the initial oral request. At the time the qualified patient makes his or her second oral request, the attending physician shall offer the patient an opportunity to rescind the request.

§ 3.07 RIGHT TO RESCIND REQUEST

A patient may rescind his or her request at any time and in any manner without regard to his or her mental state. No prescription for medication under this Act may be written without the attending physician offering the qualified patient an opportunity to rescind the request.

§ 3.08 WAITING PERIODS

No less than fifteen (15) days shall elapse between the patient's initial oral request and the writing of a prescription under this Act. No less than 48 hours shall elapse between the patient's written request and the writing of a prescription under this Act.

§ 3.09 MEDICAL RECORD DOCUMENTATION REQUIREMENTS

The following shall be documented or filed in the patient's medical record:

(1) All oral requests by a patient for medication to end his or her life in a humane and dignified manner;

(2) All written requests by a patient for medication to end his or her life in a humane and dignified manner;

(3) The attending physician's diagnosis and prognosis, determination that the patient is capable, acting voluntarily and has made an informed decision;

(4) The consulting physician's diagnosis and prognosis, and verification that the patient is capable, acting voluntarily and has made an informed decision;

(5) A report of the outcome and determinations made during counseling, if performed;

(6) The attending physician's offer to the patient to rescind his or her request at the time of the patient's second oral request pursuant to Section 3.06; and

(7) A note by the attending physician indicating that all requirements under this Act have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed.

§ 3.10 RESIDENCY REQUIREMENT

Only requests made by Oregon residents, under this Act, shall be granted.

§ 3.11 REPORTING REQUIREMENTS

(1) The Health Division shall annually review a sample of records maintained pursuant to this Act.

(2) The Health Division shall make rules to facilitate the collection of information regarding compliance with this Act. The information collected shall not be a public record and may not be made available for inspection by the public.

(3) The Health Division shall generate and make available to the public an annual statistical report of information collected under Section 3.11(2) of this Act.

§ 3.12 EFFECT ON CONSTRUCTION OF WILLS, CONTRACTS AND STATUTES

(1) No provision in a contract, will or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end his or her life in a humane and dignified manner, shall be valid.

(2) No obligation owing under any currently existing contract shall be conditioned or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner.

§ 3.13 INSURANCE OR ANNUITY POLICIES

The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. Neither shall a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy.

§ 3.14 CONSTRUCTION OF ACT

Nothing in this Act shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with this Act shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law.

SECTION 4
IMMUNITIES AND LIABILITIES

§ 4.01 IMMUNITIES

Except as provided in Section 4.02:

(1) No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with this Act. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner.

(2) No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with this Act.

(3) No request by a patient for or provision by an attending physician of medication in good faith compliance with the provisions of this Act shall constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator.

(4) No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under this Act, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

§ 4.02 LIABILITIES

(1) A person who without authorization of the patient willfully alters or forges a request for medication or conceals or destroys a rescission of that request with the intent or effect of causing the patient's death shall be guilty of a Class A felony.

(2) A person who coerces or exerts undue influence on a patient to request medication for the purpose of ending the patient's life, or to destroy a rescission of such a request, shall be guilty of a Class A felony.

(3) Nothing in this Act limits further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.

4) The penalties in this Act do not preclude criminal penalties applicable under other law for conduct which is inconsistent with the provisions of this Act.

SECTION 5
SEVERABILITY

§ 5.01 SEVERABILITY

Any section of this Act being held invalid as to any person or circumstance shall not affect the application of-any other section of this Act which can be given full effect without the invalid section or application.

SECTION 6
FORM OF THE REQUEST

§ 6.01 FORM OF THE REQUEST

A request for a medication as authorized by this act shall be in substantially the following form:

REQUEST FOR MEDICATION
TO END MY LIFE IN A HUMANE
AND DIGNIFIED MANNER

I, _____, am an adult of sound mind.

I am suffering from _____, which my attending physician has determined is a terminal disease and which has been medically confined by a consulting physician.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care and pain control.

I request that my attending physician prescribe medication that will end my life in a humane and dignified manner.

INITIAL ONE:

_____ I have informed my family of my decision and taken their opinions into consideration.

_____ I have decided not to inform my family of my decision.

_____ I have no family to inform of my decision.

I understand that I have the right to rescind this request at any time.

I understand the full import of this request and I expect to die when I take the medication to be prescribed.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

Signed:

_____

Dated:

_____

DECLARATION OF WITNESSES

We declare that the person signing this request:

(a) Is personally known to us or has provided proof of identity;

(b) Signed this request in our presence;

(c) Appears to be of sound mind and not under duress, fraud or undue influence;

(d) Is not a patient for whom either of us is attending physician.

_____

Witness 1/Date

_____

Witness 2/Date

NOTE: One witness shall not be a relative (by blood, marriage or adoption) of the person signing this request, shall not be entitled to any portion of the person's estate upon death and shall not own, operate or be employed at a health care facility where the person is a patient or resident. If the patient is an inpatient at a health care facility, one of the witnesses shall be an individual designated by the facility.

The Act set forth above (Ballot Measure No. 16) was proposed by initiative petition and was enacted by a vote of 627,980 to 596,018 at the regular general election on November 8, 1994. By proclamation of the Governor dated December 7, 1994, the Act was declared to have received an affirmative majority of the total number of votes cast thereon and to be in full force and effect as provided in section 1, Article IV, Oregon Constitution on December 8, 1994.

[file mark: Aug. 3, 1995]

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

Gary LEE, et al.,	)	
	)	
Plaintiffs,	)	Civil No. 94-6467-HO
	)	
v.	)	DECLARATORY
	)	JUDGMENT AND
STATE OF OREGON, et al.,	)	PERMANENT
	)	INJUNCTION
Defendants.	)	
	)	

The court, having considered the parties' dispositive motions, having granted plaintiffs' motion for summary judgment as to the Equal Protection Clause claim, and having granted certain of defendants' motions for summary judgment as to standing, intervention and immunity, grants plaintiffs Dutson, Elsner, Willows Residential Care Facility, and Maryville Nursing Home a declaratory judgment and permanent injunction against the remaining defendants.

IT IS HEREBY ORDERED, ADJUDGED, AND DECREED that:

(1) Oregon's Death With Dignity Act ("Measure 16") violates the Equal Protection Clause of the Fourteenth Amendment of the Constitution of the United States;

(2) Defendants are permanently enjoined from recognizing the constitutionality of Measure 16;

(3) Defendant District Attorney Harcleroad is permanently enjoined from recognizing any exceptions from criminal law created by Oregon Ballot Measure 16 in the exercise of his criminal enforcement duties;

(4) Defendant members of the State Board of Medical Examiners are permanently enjoined from recognizing any exceptions from law or regulation governing physician's conduct created by Oregon Ballot Measure 16 in the exercise of their duties involving licensure, quality control, continuing education, and discipline of physicians;

Nominal security is set in this matter in the amount of $1.00, to be posted in the form of cash or bond with the clerk of this court.

This injunction is binding upon the defendants, their agents, servants, employees, and attorneys, and upon those persons in active concert or participation with them who receive actual notice of this order by personal service or otherwise.

IT IS SO ORDERED.

DATED THIS 3rd day of August, 1995.

/s/ Michael R. Hogan
UNITED STATES DISTRICT JUDGE

[file mark: Aug. 3, 1995]

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

Gary LEE, et. al.,	)	
	)	
Plaintiffs,	)	Civil No. 94-6467-HO
	)	
v.	)	OPINION
	)	(Equal Protection)
STATE OF OREGON,	)	
	)	
Defendants.	)	
	)	

In November 1994, Oregon voters narrowly approved a ballot initiative that allows a terminally ill adult to obtain a doctor's prescription for a fatal drug dosage for the express purpose of ending their life. The Oregon Death With Dignity Act ("Measure 16")[1] is the first of its kind in this country, and it is an understatement to say that the Act invokes profound questions of constitutional dimension. Plaintiffs claim that Measure 16 violates the Equal Protection and Due Process Clauses of the Fourteenth Amendment of the Constitution (Counts One, Two, and Four), statutory and First Amendment

[1]The term "assisted suicide" shall be used throughout this opinion as a term of art and general description of Measure 16 subject matter.

rights of freedom to exercise religion and to associate (Count Five), and the American with Disabilities Act ("ADA") (Count Three). (Third Amended Complaint, # 170).

Under the United States Constitution and the system it establishes, the resolution of an issue such as the legality of physician assisted suicide is, in the first instance, left to the democratic processes of a state. Although the complexity of life and death decisions may call for legislative participation, the judiciary cannot simply defer to state legislative processes when presented with a law which may not provide adequate constitutional guidance and protection to citizens. A state-sanctioned option designed to hasten death induces hesitation and reflection. It is the court's duty to carefully and conscientiously address any constitutional issues. Compassion, justice, prudence, and fortitude are all ingredients in the law, but the guiding "compass is the Constitution of the United States." *Compassion in Dying v. State of Washington,* 49 F.3d 586, 594 (9th Cir. 1995).

Requiring that issues relating to physician assisted suicide be addressed within constitutional limits does not frustrate the authority of citizens to govern themselves. To the contrary, it ensures the integrity of the voting process by recognizing the deeply imbedded constitutional principle that certain fundamental rights may not be dispensed with by a majority vote.

I. EQUAL PROTECTION CLAUSE

Plaintiffs allege that the provisions of Measure 16 violate the Equal Protection Clause of the Fourteenth Amendment to the Constitution. They argue that Measure 16's classification or

coverage to the "terminally ill" is not rationally related to a legitimate state interest.[2]

The Fourteenth Amendment commands, in part, that no state shall "deny to any person within its jurisdiction the equal protection of the laws." U.S. Const. amend. XIV, § 1. The Equal Protection Clause does not forbid differentiating between classes of persons. Rather, it simply prohibits the states from treating persons differently who are, in all relevant respects, alike. *Nordlinger v. Hahn*, 505 U.S. 1, 10, 112 S.Ct. 2326, 2331, 120 L.Ed.2d 1 (1992) (citation omitted).

Legislation is presumed valid if a classification drawn by a statute is rationally related to a legitimate state interest. *Schweiker v. Wilson*, 450 U.S. 221 (1981). The Equal Protection Clause allows wide latitude in social legislation. *United States Railroad Retirement Board v. Fritz*, 449 U.S. 166, 174, 101 S.Ct. 453, 459, 66 L.Ed.2d 368 (1980). A legitimate state interest must encompass the interests of the members of the community at large, as well as disadvantaged and favored classes. Legislative decisionmakers are not required to articulate the rationale supporting a classification, and the state is not required to produce evidence or empirical data to support it. *Heller v. Doe by Doe*, 509 U.S. 312, —, 113 S.Ct. 2637, 125 L.Ed.2d 257 (1993). It is irrelevant that the voters rather than a legislative body enacted the statute for purposes of this constitutional review. *Citizens Against Rent Control v. City of Berkeley*, 454 U.S. 290, 293, 295, 102 S.Ct. 434, 436, 437, 70 L.Ed.2d 492 (1981). Plaintiffs have the burden of proving any violation of the Equal Protection Clause. *Burlington Northern*

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[2]The court has, therefore, limited its analysis and is not deciding whether a heightened or strict scrutiny test may apply if Measure 16 implicates a fundamental liberty interest.

Railroad Co. v. Department of Public Service Regulation, 763 F.2d 1106, 1113 (9th Cir.1985).

A classification "must be upheld against an equal protection challenge if there is any reasonably conceivable state of facts that could provide a rational basis for the classification." *F.C.C. v. Beach Communications, Inc.*, 508 U.S. 307, ----, 113 S.Ct. 2096, 2100, 124 L.Ed.2d 211 (1993). A classification rationally furthers a state interest when there is some fit between the disparate treatment and the legislative purpose. *See Katzenbach v. Morgan*, 384 U.S. 641, 657, 86 S.Ct. 1717, 1727, 16 L.Ed.2d 828 (1966). When faced with doubts as to the constitutionality of a statute, the court must first determine whether it is fairly possible to interpret the statute in a manner that renders it valid. *Communications Workers of America v. Beck*, 487 U.S. 735, 762, 108 S.Ct. 2641, 2657, 101 L.Ed.2d 634 (1988). However, "statutory construction may not be pressed to the point of disingenuous evasion." *Id.* at 762, 108 S.Ct. at 2657 (quotation omitted).

A state is free to create a classification scheme so long as it does not invidiously discriminate. *City of Cleburne, Tex. v. Cleburne Living Center*, 473 U.S. 432, 105 S.Ct. 3249, 87 L.Ed.2d 313 (1985) (labeled "irrational prejudice"); *Lehnhausen v. Lake Shore Auto Parts Co.*, 410 U.S. 356, 93 S.Ct. 1001, 35 L.Ed.2d 351 (1973); *Jackson Water Works v. Public Utilities Com'n*, 793 F.2d 1090, 1093 (9th Cir.1986). The state may not rely on a classification whose relationship to an asserted goal is so attenuated as to render the distinction arbitrary or irrational. *Zobel v. Williams*, 457 U.S. 55, 102 S.Ct. 2309, 72 L.Ed.2d 672 (1982); *United States Dept. of Agriculture v. Moreno*, 413 U.S. 528, 93 S.Ct. 2821, 37 L.Ed.2d 782 (1973); *Nordlinger v. Hahn*, 505 U.S. at 18, 112 S.Ct. at 2336. However, the underinclusiveness or overinclusiveness of a classification may be so severe that it

cannot be said that the legislative distinction "rationally furthers" the state interest. *Burlington Northern Railroad Co. v. Ford*, 504 U.S. 648, 653-54, 112 S.Ct. 2184, 2188, 119 L.Ed.2d 432 (1992).

Equal protection analysis is used to determine whether a classification is properly drawn. Plaintiffs argue that there is no legitimate state interest underlying Measure 16, because statistics show that only 2-4% of the terminally ill actually commit suicide. However, as noted, a classification is valid for equal protection purposes as long as there is some "fit" between the disparate treatment and the legislative purpose. On the other hand, intervenor defendants argue that Measure 16 is only the first step toward legalizing physician assisted suicide for others who consent.[3] The Ninth Circuit in discussing whether a

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[3]Certain of the defendants would limit the court's analysis of the constitutional issues to the context of the terminally ill class as defined by Measure 16, and the court has so limited its analysis. Nonetheless, the candor of intervenor defendants boldly presents the underlying issue: what are the boundary lines, if any, to state-sanctioned suicide? While a diagnosis of terminal illness with less that six months to live may be a persuasive rational basis for some to choose suicide, there is little limit to the justifications which can be advanced for state-sanctioned suicide. Where in the Constitution do we find distinctions between the terminally ill with six months to live, the terminally ill with one year to live, paraplegics, the disabled, or any category of people who have their own reasons for not wanting to continue living?

This could be a slippery slope indeed. The Supreme Court has cautiously and explicitly excluded assisted suicide from the scope of its decisions concerning a "right to die." *Cruzan*, 497 U.S. at 280, 110 S.Ct. at 2852. It has identified the considerations for determining when a right "not readily identifiable in the Constitution's text" is deserving of constitutional protection. *Bowers v. Hardwick*, 478 U.S. 186, 191, 106 S.Ct. 2841, 2844, 92 L.Ed.2d 140 (1986). A right must be "implicit in the concept of ordered liberty" so that neither liberty nor justice would exist if it were sacrificed. The right must be "deeply rooted in the Nation's history and tradition." Id.

terminally ill patient had a liberty interest in a "right to die" reasoned:

> If at the heart of liberty protected by the Fourteenth Amendment is the uncurtailable ability to believe and to act on one's deepest beliefs about life, the right to suicide and the right to assistance in suicide are the prerogative of at least every sane adult. The attempt to restrict such rights to the terminally ill is illusory. If such liberty exists in this context, . . . every man and woman in the United States must enjoy it. . . . The conclusion is a *reductio ad absurdum*. . . .

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at 191-192, 106 S.Ct. at 2844. Courts have considered the historical treatment of suicide in analyzing an alleged constitutional right to assisted suicide, and states have traditionally penalized acts of suicide and assisted suicide. *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. at 294-295, 110 S.Ct. at 2859-60 (Scalia, J., concurring). Traditionally, physician assisted suicide has been regarded as contrary to the Hippocratic Oath which states in part:

> To please no one will I prescribe a deadly drug, nor give advice which may cause his death.

STEADMAN'S MEDICAL DICTIONARY (5th Unabridged Lawyers' Ed), at 650.

It is noteworthy that the Declaration of Independence refers to life as "inalienable," presumably a benefit that cannot be easily waived or forfeited. The Ninth Circuit recognized that: "[t]ort law and criminal law have never recognized a right to let others enslave you, mutilate you, or kill you, even with your consent." *Compassion in Dying*, 49 F.3d at 594.

The Ninth Circuit further stated:

> In two hundred and five years of our existence no constitutional right to aid in killing oneself has ever been asserted and upheld by a court of final jurisdiction. Unless the federal judiciary is to be a floating constitutional convention, a federal court should not invent a constitutional right unknown to the past and antithetical to the defense of human life that has been a chief responsibility of our constitutional government. Id. at 591.

Compassion in Dying, 49 F.3d at 591. While the practical effect of a state law may be to create some inequality between particular classes of persons on the ground that the legislature has taken only one step, it cannot create an illusory classification where the reasons for the law apply equally to all members of the public.

Defendants argue that Measure 16 cannot violate plaintiffs' right to equal protection of the laws, because it does not require any action, rather it merely provides an optional procedure. In theory, the consent embodied in Measure 16 equally protects the right of a terminally ill person to go on living and the right to choose to die. This consent is purportedly based on a person's own rational assessment of the quality and value of their life.

As Measure 16 itself recognizes, however, there may be terminally ill persons who are suffering from impaired judgment and yet express a wish to die. Their status is incompatible with autonomy and personal decisionmaking. Where terminally ill persons are provided the means of hastening death, there is a potential for exposing members of society to life-threatening mistakes and abuses. Therefore, a crucial inquiry under an equal protection analysis is whether the safeguards provided in Measure 16 are sufficient to justify treating terminally ill patients differently than others.

Plaintiffs argue that the "terminally ill" classification denies them equal protection of the laws, because non-terminally ill persons are entitled to certain statutory "protections" under Oregon law which are arbitrarily and irrationally abrogated by Measure 16. Specifically, they point to ORS 163.125, ORS

161.205, ORS 426.070, ORS 677.095, and ORS 677.190.[4] These laws serve to protect vulnerable people who might otherwise seek suicide in response to treatable depression, mental illness, or coercion. After noting that a majority of states have laws imposing criminal penalties on one who assists a suicide, the Supreme Court has stated: "We do not think a State is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death." *Cruzan v. Director, Missouri Dept. of Health,* 497 U.S. 261, 280, 110 S.Ct. 2841, 2852, 111 L.Ed.2d 224 (1990). The state interests underlying these statutes include preservation of life and protection against suicide.

The state defendants claim the following interests in creating an exception for terminally ill persons under Measure 16: (1) avoiding unnecessary pain and suffering;[5] (2) preserving and enhancing the right of competent adults to make their own critical health care decisions; (3) avoiding tragic cases of attempted or successful suicides in a less humane and dignified

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[4]ORS 163.125 establishes the crime of manslaughter in the second degree for recklessly or intentionally causing or aiding another person to commit suicide. ORS 161.205 provides that a person acting under a reasonable belief that another person is about to commit suicide may use reasonable physical force to thwart the result. ORS 677.190(1) provides that the Board of Medical Examiners for the state of Oregon may take disciplinary action against a physician for "unprofessional or dishonorable conduct," which includes any conduct contrary to recognized standards of ethics of the medical profession or which might constitute a danger to the health or safety of a patient. *See also* ORS 677.188(4)(a). Two of these statutes are more fully discussed in the text of this opinion: ORS 426.070 *et seq.*, establishing the procedure for civil commitment, and ORS 677.095, establishing a physician's standard of care.

[5]The court notes that although defendants argue that one purpose of Measure 16 is to end intractable pain, the statute does not require any showing of pain to acquire a lethal prescription.

manner; (4) protecting the terminally ill and their loved ones from financial hardships they wish to avoid; and (5) protecting the terminally ill and their loved ones from unwanted intrusions into their personal affairs by law enforcement officers and others. (Defendants' Reply Memorandum in Support of Motion for Summary Judgment (# 172) at 16).

It is "rational" to conclude that competent terminally ill persons may not want protection from their suicidal impulses. Preventing suicide may simply mean prolonging suffering for a person who has no hope of a significant natural life ahead.[6] Therefore, it may be a valid public policy to allow choice based on principles of autonomy and self-determination — the right to control one's body, destiny, and health care.

The basic premise underlying the state's argument that Measure 16 is constitutional is that terminally ill persons consent to the drug overdose. Thus, the measure excludes the "incompetent" from opting for assisted suicide, because their consent cannot be deemed voluntary or valid. The problem is that the procedures designed to differentiate between the competent and incompetent are not sufficient. For example, one safeguard recognized in withdrawal of life support cases, but not under Measure 16, is the involvement of third parties to provide a "substituted judgment" on behalf of an incompetent person. The third parties, usually family members or relatives, act as proxies to implement what a patient would choose under particular circumstances. *Cruzan*, 497 U.S. at 279-80, 110 S.Ct. at 2852; ORS 127.510(1) (provides that a capable adult may designate in writing a competent adult to serve as attorney-in-fact for health care and to direct withdrawal of life support).

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[6]It is equally "rational" to conclude that a person could never receive a benefit from self-destruction.

Another example is ORS 426.070, which provides a procedure for civil commitment of mentally ill persons who, because of a mental disorder, are dangerous to themselves. *See also* ORS 426.005(1)(d)(A). Under this procedure, a "treating" physician licensed by the Board of Medical Examiners may temporarily hold such individuals in a health care facility for up to twelve hours if that physician believes them to be dangerous to themselves, and in conjunction with a qualified mental health professional, may hold them up to five days. ORS 426.231; ORS 426.232. A judge is required to appoint at least one qualified "examiner" to evaluate the patient and provide a report prior to a commitment hearing. ORS 426.110; ORS 426.120. A qualified examiner is defined as a physician licensed to practice psychiatry or who is certified to make examinations by the Mental Health and Developmental Disability Services Division. ORS 426.110(2)(b). None of these safeguards apply to Measure 16.

Without the protections provided in other situations, Measure 16 requires "attending" and "consulting" physicians who may not be psychiatrists, psychologists, or counselors to make an evaluation whether a condition is causing impaired judgment,[7] if a patient is depressed, or suffering from a psychiatric or psychological disorder. This is the final evaluation for persons, whom the physicians believe, are not suffering from impaired judgment. The Measure also relies on them to decide when a person's request is voluntary and not the product

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[7]Measure 16 defines an "attending" physician as one who is primarily responsible for the care and treatment of a terminal disease. It defines "consulting" physician as one who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding a patient's disease. These physicians will be referred to as "treating" physicians for purposes of this opinion. They are required to evaluate whether a patient may be suffering from a psychiatric or psychological disorder, or depression causing impaired judgment. (§ 3.03).

of undue influence.[8] There is no requirement that the person consult a certified social worker or other specialist to explore social services which might assist the person to live in greater comfort. Also, it is the treating physician's responsibility to inform the person of "feasible alternatives," including "comfort care, hospice care and pain control." (§ 3.01(2)(e)).

It is undisputed that one of the factors that motivates suicide is depression. Suicide requests may represent a plea for help by a distraught person in physical and emotional pain. Under Measure 16, a treating physician must determine when a person is beyond help and not merely suffering from treatable depression common in people with terminal illnesses. Seriously ill people commonly suffer from alienation, guilt and feelings of unworthiness. They are susceptible to even subtle suggestions that reinforce these feelings. Clinical imponderables such as severity of pain, gradations of suffering, and prognosticating accurately are difficult in themselves. They may be compounded when a person seeks assisted suicide, or the treating physician is frustrated or inclined to impose their values on a person.[9] The

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[8]Measure 16 does provide some protection from undue influence. Section 4.02(2) provides:

> A person who coerces or exerts undue influence on a patient to request medication for the purpose of ending the patient's life, or to destroy a rescission of such a request, shall be guilty of a Class A felony.

[9]The Ninth Circuit has stated that "[p]hysician-assisted suicide is fundamentally incompatible with the physician's role as healer." *Compassion in Dying*, 49 F.3d at 592. In addition, it noted that a physician's search for ways to combat disease would be affected, "if killing were as acceptable an option for the physician as curing." *Id.*

The Ninth Circuit recognized that protecting vulnerable patients from psychological pressure to consent to suicide was important. *Id.* It reasoned that for all medical treatments including assisted suicide, physicians decide

problem of inadequate mental evaluation is compounded by imprecision in defining "terminal disease." Even for physicians who specialize in treating a terminal disease, no precise definition is medically or legally possible, since only in hindsight is it known with certainty when someone is going to die. As the Ninth Circuit noted, the terminally ill category is "inherently unstable." *Compassion in Dying*, 49 F.3d at 590.

Measure 16 does not provide for an independently chosen consulting physician to confirm that a person is capable and acting voluntarily, rather it is the attending physician's responsibility to make the referral. (§ 3.01). This does not assure a second, independent medical examination to closely and carefully scrutinize a person's "qualification" to use Measure 16. The Measure provides a person with a short time for reflection, no less than 15 days between the initial oral request and the writing of the prescription and no less than 48 hours between the patient's written request and the writing of the prescription. (§ 3.08). The possibility that a judgment impairing disorder will resolve itself within this short time frame is unlikely.[10] Also, from a broader view, there is no independent

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which patients are candidates. "Physician neutrality and patient autonomy, independent of their physician's advice, are largely myths. . . Once the physician suggests suicide or euthanasia, some patients will feel that they have few, if any alternatives, but to accept the recommendation." *Id.* The court also discussed the particular vulnerability of the poor and the disabled. Finally, the Ninth Circuit mentioned preventing the abuse that occurs in the Netherlands where assisted suicide is permitted in response to repeated requests from a suffering, competent patient.

[10]As noted previously, the classification of a terminally ill patient with six months or less to live is only one of a myriad of classifications which would support a rational basis for a decision to commit suicide. Would the same procedures for determining competency and the same 15 day waiting period withstand constitutional scrutiny as applied to a 19 year old paraplegic contemplating suicide? Again, where in the Constitution do we find the

oversight for the decision and implementation of an assisted suicide request by medical professionals, i.e., review by a probate court, as there is with civil commitment.[11] With death at issue under Measure 16, the court is unable to conceive of a set of facts under which it would be rational to not require mental and social evaluations by appropriately trained professionals.

ORS 677.095 establishes the standard of care for physicians who treat patients outside Measure 16 parameters. It provides, in relevant part: "A physician . . . has the duty to use that degree of care, skill and diligence which is used by ordinarily careful physicians . . . in the same or similar circumstances in the community of the physician . . . or a similar community." An Oregon physician's actions are judged by the generally accepted and ordinary level of skill expected by the medical profession. For example, this standard applies to an Oregon physician's conduct related to withdrawal of life support. ORS 127.560(1)(b). On the other hand, Measure 16 adopts a subjective "good faith" standard of care for a physician's participation under the Act.[12] An Oregon appellate court has

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compass to chart our way through this state-sanctioned dispensation of death?

[11]In fact, under Measure 16 there is no family notification requirement at the point of receiving the physician-prescribed drug. Section 3.05 provides:

> The attending physician shall ask the patient to notify next of kin of his or her request for medication pursuant to this Act. A patient who declines or is unable to notify next of kin shall not have his or her request denied for that reason.

[12]Measure 16's "Immunities and Liabilities" section provides in relevant part:

> § 4.01 Immunities
> Except as provided in Section 4.02:
> (1) No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with this Act.

expressly rejected the insertion of the "good faith" concept into the usual consideration of whether physicians exercise reasonable care. *Ellis v. Springfield Women's Clinic, P.C.*, 67 Or.App. 359, 678 P.2d 268, 270, *rev. den.*, 297 Or. 228, 683 P.2d 91 (1984). In remanding for a new trial, the Oregon Court of Appeals stated: "The introduction of that concept allows the jury to consider the motivations of the defendants. Such a consideration has no place in an action for ordinary negligence. . . . " *Id.*, 678 P.2d at 270.

Is there a rational basis for Oregon to immunize physicians from liability for actions taken in "good faith" under Measure

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. . . (3) No request by a patient for or provision by an attending physician of medication in good faith compliance with the provisions of this Act shall constitute neglect for any purpose of law. . . .

The "participation" described in Section 4.01(1) includes these acts of the "attending physician":

(1) Making the initial determination whether a patient has a terminal disease (§ 3.01(1));

(2) Making the initial determination whether a patient is capable and has voluntarily made the request for medication to end his or her life (§ 3.01(1));

(3) Informing the patient of the potential risks associated with taking the medication to be prescribed, and the probable result of taking the medication (§ 3.01(2));

(4) Referring the patient to counseling if it is believed a patient may be suffering from a psychiatric or psychological disorder, or depression causing impaired judgment (§ 3.03);

(5) Verifying that the patient is making an informed decision immediately prior to writing the prescription for a lethal dose of medication (§ 3.04); and

(6) Prescribing a lethal dose of medication, except to patients who may be suffering from a psychiatric or psychological disorder, or depression causing impaired judgment (§ 3.03).

"Participation" also includes acts of "consulting physicians" in confirming a diagnosis, determining whether a patient is capable of acting voluntarily and has made an informed decision; and the acts of a state licensed psychiatrist or psychologist who performs psychological counseling. (§ 3.02, § 1.01(4), § 3.03).

16, irrespective of any medical community standard which applies to their actions outside Measure 16? The plain inference from Measure 16 is that it is irrelevant whether physicians objectively act reasonably, or instead act negligently. The court finds that there is no set of facts under which it would be rational for terminally ill patients under Measure 16 to receive a standard of care from their physicians under which it did not matter whether they acted with objective reasonableness, according to professional standards. This defect goes to the very heart of the state's reliance on a person's consent to die. The physician is allowed to negligently misdiagnose a person's condition and competency and negligently prescribe a drug overdose, so long as those actions are in "good faith." This distinction in the physician's standard of care under Measure 16 is not rationally related to any legitimate state interest.[13]

Any state interest which underlays Measure 16 is furthered when a person takes a lethal drug dosage. Yet, there is no requirement that the person take the lethal overdose at the time of the prescription or under the supervision of a physician. It provides that the attending physician may prescribe drugs, but does not limit that prescription to drugs which must be ingested. A prescription may be taken intravenously or a physician may establish a device for releasing the drug by a switch or gas mask. These possibilities subject a vulnerable person to potential abuse at the hands of others, and without the person's knowledge or consent. Measure 16 does nothing to ensure that the decision to commit suicide is rationally and voluntarily made at the time of death. As a result, Measure 16 purports to recognize

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[13]Again, to underscore the constitutional defect in Measure 16, one only need contemplate the same procedures as applied to a classification based upon disability. Would the suspension of the duty of reasonable care otherwise owed by a physician to their disabled patient withstand an equal protection challenge to physician assisted suicide for that patient?

a competent terminally ill person's choice to obtain the means to end their life should they commit suicide while competent, incompetent, or unduly influenced at some future time, including hours, days, weeks, or months later. A person decides when, where, and most important, whether to take the prescribed drug without any legal protection.

There is no set of facts under which it would be rational to conclude that a state may sanction providing people the means to commit suicide without consideration of their circumstances at the time of the suicide. This is not simply a matter of an "imperfect fit" between the classification of "terminally ill patient" and a goal of permitting assisted suicide. Given the imprecision and inadequacy of protections leading to the prescription of drugs, the relationship between Measure 16's classification and the goal of permitting assisted suicide is too attenuated without some protection at the time of taking the fatal drug dosage.

Measure 16 provides a means to commit suicide to a severely overinclusive class who may be competent, incompetent, unduly influenced, or abused by others. The state interest and the disparate treatment are not rationally related and Measure 16, therefore, violates the Constitution of the United States.[14]

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[14]Plaintiffs did not file a separate motion for summary judgment. They argued, in effect, that if defendants admitted certain facts related to the adequacy of the Measure 16 safeguards, then they would be entitled to summary judgment. (Plaintiffs' Brief in Opposition to Defendants' & Intervenors' Motions to Dismiss & For Summary Judgment (# 168) at 2-4). The court construes that pleading (# 168) as plaintiffs' motion for summary judgment. It is not necessary to decide factual issues to grant summary judgment in plaintiffs' favor on the equal protection claim.

II. OTHER CLAIMS

It is not necessary to decide motions related to plaintiffs' Due Process (Count Two), Freedoms of Association and Exercise of Religion (Count Five), ADA (Count Three), and void for vagueness (Count Four) claims.

III. CONCLUSION

Individuals and their families and physicians make decisions regarding dying every day, and with limited legal guidance. The fact that people often consult their physicians in this situation is a good argument that assisted suicide is viewed most appropriately as a personal medical matter. Certainly privacy is an important right that people cherish and enjoy.

However, private medical matters become affairs of government when the state sanctions them. It is precisely because the state of Oregon decided to sanction assisted suicide with its irrevocable consequences that the process must withstand constitutional scrutiny.

Measure 16 singles out terminally ill persons who want to commit suicide and excludes them from protection of Oregon laws that apply to others. Residents of Oregon are entitled to protection from committing suicide if found to be a danger to themselves, and after evaluation by a psychiatrist or other state certified mental health specialist. Under this involuntary commitment procedure, "treating physicians," those who treat physical ailments, are not recognized as sufficiently qualified to evaluate their patient's mental impairments, except in emergency and temporary circumstances. Under Measure 16, the very lives of terminally ill persons depend on their own rational assessment of the value of their existence, and yet there is no requirement that they be evaluated by a mental health specialist.

Treating physicians may not be sufficiently qualified alone to evaluate mental impairments for the general public, but are given the significant role of deciding whether their patient may be suffering from a "psychiatric or psychological disorder or depression causing impaired judgment." For some, this is their only and final mental evaluation. In addition, these physicians may make this mental evaluation, and perform other responsibilities under Measure 16 based on a subjective, good faith belief. Contrary to the physician's "reasonable" standard of care for other patients, under Measure 16 there is no bar to a physician acting negligently. In addition, Measure 16 abandons the terminally ill person at the time the physician provides a lethal prescription. It fails to even acknowledge the most critical time, that of death. It provides a means to commit suicide to people who may be competent, incompetent, unduly influenced, and/or abused at the time of death. There is no distinction.

One Supreme Court justice has emphasized the importance of the Equal Protection Clause in protecting persons from substantively unreasonable laws:

> What protects us . . . from being assessed a tax of 100% of our income above the subsistence level, from being forbidden to drive cars, or from being required to send our children to school for 10 hours a day. . . . Our salvation is the Equal Protection Clause, which requires the democratic majority to accept for themselves . . . what they impose on you and me.[15]

Measure 16 withholds from terminally ill citizens the same protections from suicide the majority enjoys. In the process, it has lowered standards and reduced protections to a degree that

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[15]*Cruzan*, 497 U.S. 261, 300, 110 S.Ct. 2841, 2862-63, 111 L.Ed.2d 224 (1990) (Scalia, J., concurring).

there is little assurance that only competent terminally ill persons will voluntarily die. The majority has not accepted this situation for themselves, and there is no rational basis for imposing it on the terminally ill.

One difficulty with Measure 16 is its inability to limit "rational suicide" to the hard cases. The suffering of some competent, terminally ill persons gives rise to compassionate arguments. However, as in other areas of law, people have not been permitted to relinquish important interests without careful scrutiny. In addition, Measure 16 is not just about whether someone can legally commit suicide, rather it concerns suicide with state involvement. The court has considered the extent to which permitting assisted suicides in the hard cases may lead to the premature deaths of terminally ill persons who may actually want to live. With state-sanctioned and physician assisted death at issue, some "good results" cannot outweigh other lives lost due to unconstitutional errors and abuses.

DATED this 3rd day of August, 1995.

/s/ Michael R. Hogan
UNITED STATES DISTRICT JUDGE

[file mark: Aug. 3, 1995]

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

Gary LEE, et al.,	)	
	)	
Plaintiffs,	)	Civil No. 94-6467-HO
	)	
v.	)	OPINION
	)	(Standing)
STATE OF OREGON, et al.,	)	
	)	
Defendants.	)	
	)	

The court must decide the status of parties to assert or defend claims in this action. Plaintiffs are two physicians, four terminally ill or potentially terminally ill patients, a residential care facility, and individual operators of residential care facilities. Defendants include the state of Oregon, the Attorney General for the State of Oregon, a district attorney, members of the Oregon Board of Medical Examiners, Oregon Health Sciences University Hospital (OHSU), and members of the Oregon State Board of Higher Education (collectively state defendants). In addition, this court allowed an Oregon physician and sponsors of Measure 16 to intervene as defendants.

The parties filed other motions relating to standing, intervention, immunity, and adding parties through pleading

amendment which are addressed by this opinion and decided by separate order on this date.

I. STANDING

Defendants argue that plaintiffs lack standing to assert their claims. Article III of the United States Constitution limits the judicial power of federal courts to "cases" and "controversies." U.S. Const., art. III. A party who invokes the court's authority must show that: (1) they have suffered an "injury in fact" or an invasion of a legally-protected interest which is concrete and particularized, and "actual or imminent," (2) there is a causal connection between the injury and the challenged conduct, and (3) it must be likely that the injury will be "redressed by a favorable decision." *Lujan v. Defenders of Wildlife,* 504 U.S. 555, 560-61, 112 S.Ct. 2130, 2136, 119 L.Ed.2d 351 (1992).

Standing distinguishes "a person with a direct stake in the outcome of a litigation — even though small — from a person with a mere interest in the problem." See *United States v. SCRAP*, 412 U.S. 669, 689 n. 14, 93 S.Ct. 2405, 2417, 37 L.Ed.2d 254 (1973). It is not to be placed in the hands of "concerned bystanders," to use simply as a "vehicle for the vindication of value interests." *Id.* However, it is not necessary to demonstrate a specific or immediate harm when challenging the constitutionality of a statute on its face. *Kines v. Day*, 754 F.2d 28, 30 (1st Cir.1985) (citing *Dombrowski v. Pfister*, 380 U.S. 479, 486, 85 S.Ct. 1116, 1120-21, 14 L.Ed.2d 22 (1965)). In some cases, the potential injury may be so severe, i.e., death, that the risk of it occurring at some future time may be sufficient for standing purposes. *Dimarzo v. Cahill,* 575 F.2d 15, 18 (1st Cir.1978), *cert. denied,* 439 U.S. 927, 99 S.Ct. 312, 58 L.Ed.2d 320 (1978). "One need not wait for the [life-threatening event to occur] before concluding that a real and present threat exists." *Id.* This rule applies when a plaintiff

has little control over whether the life-threatening event will occur. *Id.*

A person may have standing to assert a facial challenge to the constitutionality of a statute which has not yet gone into effect. *See Hodel v. Virginia Surface Min. & Reclam. Ass'n*, 452 U.S. 264, 298, 101 S.Ct. 2352, 2371-72, 69 L.Ed.2d 1 (1981); *see also Doulin v. White*, 549 F.Supp. 152, 154 (E.D.Ark.1982) (citing *Blum v. Yaretsky*, 457 U.S. 991, 102 S.Ct. 2777, 73 L.Ed.2d 534 (1982)). There is no precise test for determining the difference between an abstract question and an Article III controversy, rather it is necessarily a question of degree. *Golden v. Zwickler*, 394 U.S. 103, 108, 89 S.Ct. 956, 959-60, 22 L.Ed.2d 113 (1969). The answer also depends on the nature of the constitutional issues and whether ad hoc factual inquiries are necessary. *See, e.g., Hodel*, 452 U.S. at 294-95, 101 S.Ct. at 2369-70.

Courts have found an insufficient connection between an alleged injury and a defendant's future conduct where it is unlikely that a plaintiff could ever be threatened by such conduct. *Golden v. Zwickler*, 394 U.S. 103, 109, 89 S.Ct. 956, 960, 22 L.Ed.2d 113 (1969); *City of Los Angeles v. Lyons*, 461 U.S. 95, 111, 103 S.Ct. 1660, 1670, 75 L.Ed.2d 675 (1983). A plaintiff does not lack standing merely because an injury may be an indirect product of a defendant's conduct. *See Allen v. Wright*, 468 U.S. 737, 757- 58, 104 S.Ct. 3315, 3327-28, 82 L.Ed.2d 556 (1984).

While standing should not depend upon a consideration of the merits of a plaintiff's claim, such a consideration may properly form one basis for a finding that standing is necessary or desirable to advance the constitutional policies at issue. *Frissell v. Rizzo*, 597 F.2d 840, 845 (3rd Cir.), *cert. denied*, 444 U.S. 841, 100 S.Ct. 82, 62 L.Ed.2d 54 (1979). Where the

injury is less tangible than actual physical or financial injury, a standing determination may turn on the court's view of the "sensitivity of the constitutional values in dispute." *Id.*

The court is required to base its decisions concerning the medical conditions of potential parties only on the record presented to it. This applies equally to plaintiffs and the proposed intervening defendants. The record reviewed here includes all of those documents received prior to the hearing on dispositive motions, as well as post-hearing submissions. This may seem insensitive because the medical conditions of these people may have improved or deteriorated between the final submissions to the court and now. The court, however, may not consider any changes that are not reflected in the written record.

The state and intervenor defendants argue that plaintiff terminally ill patients lack standing because they have not demonstrated an actual or imminent injury which is fairly traceable to their conduct. However, the risk of death is a sufficient injury for plaintiffs Eric Dutson and Janice Elsner and properly a basis for standing if sufficiently connected to Measure 16. *See Dimarzo v. Cahill, supra*. Measure 16 requires that a qualified person have an "incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months." (§ 1.01(12)).

Plaintiff Dutson is an AIDs patient who has been given a prognosis of six months to live. (Plaintiffs' Supplemental Statement of Material Facts (# 174)). Plaintiff Elsner has a progressive form of muscular dystrophy and has already lived longer than doctors expected. *Id.* She has suffered clinical depression that resulted in ambivalence about whether she wanted to continue living. (Defendants' Supplemental Statement of Material Facts (# 164)). Both of these individuals have

histories of depression. *Id.* Currently, they are not contemplating suicide and have expressed opposition to assisted suicide to their physicians. However, their medical histories indicate they are likely to become depressed and unable to control the timing or severity of that depression.[1] There is sufficient evidence that plaintiffs Dutson and Elsner are at a significant risk of harm due to circumstances beyond their control with Measure 16 in effect. These plaintiffs have standing to assert a facial challenge to Measure 16. The nature of the constitutional issues they assert does not require resolution on a case-by-case basis.

There is significant evidence in the record that depression is a major cause of suicide and is many times undiagnosed. Measure 16 requires drawing a fine line between rational, depressed terminally ill persons who want assisted suicide and terminally ill persons who express suicidal wishes, but are not capable of rational choice. It is about people who are most vulnerable to undue pressure. It is about permitting physicians to make decisions concerning mental competency and to provide the means by which people end their lives. Oregon's criminal homicide, civil commitment, and physician standard of care and

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[1]On the other hand, the record indicates that plaintiff Jeffrey Weinkauf is a diabetic who takes insulin and is healthy. He has not been given a prognosis of six months to live, has not indicated any desire to commit suicide, and has no history of severe depression. Plaintiff Claudine Stotler was told in 1992 that she had six months to live. (Plaintiffs' Supplemental Statement of Material Facts (# 174)). She has a cancerous lung and liver, and pancreatic and brain tumors. *Id.* Her doctor thought the cancer had metastasized, and that there was nothing further that could be done medically. (Plaintiffs' Supplemental Statement of Material Facts: Plaintiffs' Supplemental Exhibit List, (# 175), Exhibit W at 11). However, the "tumor review board" thought that surgery might help. *Id.* She did undergo multiple surgeries in 1992-1994 and has not received an update on her prognosis. Neither plaintiff Weinkauf or plaintiff Stotler have demonstrated a sufficient threat of harm from Measure 16, and, therefore do not have standing.

disciplinary laws do not apply in equal measure to those who participate in Measure 16. It is difficult, at best, to decide Article III standing based on a terminally ill person's mental status. Plaintiffs Dutson and Elsner should not be denied standing, because they have not become so depressed they want to commit suicide, or until they receive and take a fatal drug dosage and either die or are close to death. As noted in the equal protection opinion, Measure 16 implements a significantly lesser standard of care for physicians. This, itself, would confer standing on these plaintiffs.

Defendants Harcleroad and members of the Oregon Board of Medical Examiners are named as defendants because they have some enforcement responsibilities regarding Measure 16.[2] The alleged injury-producing conduct is their recognition of Measure 16's validity and enforcement of its terms. Defendants' alleged conduct in recognizing and enforcing an unconstitutional statute would be a sufficient indirect cause of any future injury to plaintiffs.

In addition, it is sufficiently likely that plaintiffs Dutson and Elsner would benefit from a judgment in this action. *See Duke Power Company v. Carolina Environmental Study Group,* 438 U.S. 59, 98 S.Ct. 2620, 57 L.Ed.2d 595 (1978); *Bryant v. Yellen*, 447 U.S. 352, 100 S.Ct. 2232, 65 L.Ed.2d 184 (1980); *University of California v. Bakke*, 438 U.S. 265, 98 S.Ct. 2733,

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[2]The evidence indicates that it is unlikely that plaintiffs Dutson or Elsner would become patients of OHSU. Both testified at their depositions that they did not expect to become OHSU patients in the future. (Supplemental Affidavit of Stephen K. Bushong (# 165), Exhibit A at 24, Exhibit B at 18). Any future injury to them due to Measure 16 would not be fairly traceable to OHSU, its president, Peter Kohler, or members of the Oregon State Board of Higher Education. *See Golden v. Zwickler, supra; City of Los Angeles v. Lyons, supra.* Plaintiffs lack standing to assert their equal protection claims against these defendants.

57 L.Ed.2d 750 (1978). Their claims are ripe. It is difficult to imagine a legal proceeding with more sensitive constitutional values at issue. It is important that plaintiffs have standing to advance their constitutional positions.

II. INTERVENORS

Certain terminally ill persons have moved to intervene as defendants. Fed.R.Civ.P. 24(a) provides that parties have a right to intervene when they are "so situated that the disposition of the action may as a practical matter impair or impede the applicant's ability to protect that interest, unless the applicant's interest is adequately represented by existing parties." Fed.R.Civ.P. 24(b) permits parties to intervene when their claim or defense and the main action have a question of law or fact in common. Myriam Coppens and Nancy Dorr move to appear as *amicus curiae*. Coppens is a certified nurse practitioner, licensed marriage family therapist, and adjunct professor. She has taken difficult calls from suicidal people for several years. The interests Coppens and Dorr seek to represent in an *amicus* capacity are adequately covered by other named defendants, and their intervention is, therefore, unnecessary.

Dorr, Anthony Lynde, Tim Shuck, and Merrill Yukich all allegedly have "terminal illnesses" as defined by Measure 16. Shuck has AIDs and the virus has traveled to his brain. He has a prognosis of less than six months to live. (Defendants' Memorandum in Opposition to Motion for Preliminary Injunction (# 69), Affidavit of Timothy W. Shuck). Lynde has been diagnosed with bone cancer that currently is in remission. Prior to its remission, he experienced considerable pain. (*Id.*, Affidavit of Anthony A. Lynde). Dorr has breast cancer that has metastasized to the sternum. She expects to undergo high dosage chemotherapy with a bone marrow rescue. (*Id.*, Affidavit of Nancy Dorr). Yukich has lung cancer. Her doctor has

informed her that she has a 20% chance to live one year, and if still alive, her chances for full recovery improve with each subsequent year.

Neither Lynde, Dorr, or Yukich have been given prognoses of six months to live. They argue that it is not necessary for them to be "qualified patients" under Measure 16 to have standing, because their interest is to protect the peace of mind of knowing they can obtain a lethal prescription in the future. Shuck is allowed to intervene because he has sufficiently demonstrated an interest to protect. The interests of Lynde, Dorr, and Yukich are adequately represented by other named parties, and intervention is not necessary.

Intervenor defendant Dr. Levin argues that plaintiff physicians Lee and Petty do not have third party standing to assert claims on behalf of their patients. This court found such third party standing for purposes of the preliminary injunction and is asked to reconsider based on a more complete record. A party who wishes to assert third party standing must demonstrate an injury in fact. *Singleton v. Wulff*, 428 U.S. 106, 114, 96 S.Ct. 2868, 2874, 49 L.Ed.2d 826 (1976). This court previously relied on direct financial impact as the basis for the physicians' injury in fact, based on *Singleton, supra*. However, intervenor defendant Dr. Levin has submitted evidence that the plaintiff physicians do not currently have patients who wish to request a Measure 16 prescription. Even if they did, these physicians are opposed to Measure 16 and would not have a sufficient personal stake to represent the interests of their patients who seek assisted suicide. *See Akron Center for Reproductive Health v. City of Akron*, 651 F.2d 1198, 1210-11 (6th Cir.1981), *cert. denied*, 456 U.S. 989, 102 S.Ct. 2268, 73 L.Ed.2d 1283, *judgment aff'd in part, rev'd in part*, 462 U.S. 416, 103 S.Ct. 2481, 76 L.Ed.2d 687 (1983). Any alleged financial loss must, therefore, be based on a decrease in "the pool of potential

fee-paying patients." This is an inadequate basis for third party standing.

III. DISMISSAL

Defendants argue that claims by the individual administrators of the residential care facilities should be dismissed. Fritz and June Beck own the plaintiff Willows Residential Care Facility. Sister Bernards is the administrator of Maryville Nursing Home. Their claims are dismissed to the extent they are asserted on behalf of the patients of the respective residential care facilities. The corporate facilities are the real parties in interest for purposes of asserting such claims. However, the individual administrators are entitled to assert First Amendment claims.

Defendants argue that the constitutional claims against the state of Oregon, the Oregon Attorney General, and OHSU should be dismissed on Eleventh Amendment immunity grounds.[3] In addition, they argue that claims against the Attorney General should be dismissed because they are not justiciable.

The Eleventh Amendment generally prohibits a federal court from exercising jurisdiction over a nonconsenting state defendant. *Pennhurst State School & Hospital v. Halderman,* 465 U.S. 89, 104 S.Ct. 900, 79 L.Ed.2d 67 (1984). The Eleventh Amendment is an explicit limitation on federal judicial power and applies to the state and its agencies "regardless of the nature of the relief sought." *Id.* at 100, 104 S.Ct. at 908. It

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[3]The 1995 Oregon Legislature passed Senate Bill 2 which establishes OHSU as an independent public corporation. Its effective date was July 1, 1995. Defendants have failed to demonstrate that Eleventh Amendment immunity applies to OHSU in its new status as a public corporation.

bars federal courts from deciding claims against a state and its agencies unless the state has "unequivocally expressed" its consent to suit or there is an "unequivocal expression of congressional intent" to abrogate Eleventh Amendment immunity. *Id.* at 99, 104 S.Ct. at 907. It is undisputed that the state of Oregon has not consented to be sued nor has Congress abrogated the states' immunity from civil rights claims. Individual state officers who do not have a sufficient connection with the enforcement of a law may be covered by Eleventh Amendment immunity. *Ex parte Young,* 209 U.S. 123, 157, 28 S.Ct. 441, 452- 53, 52 L.Ed. 714 (1908); *Fitts v. McGhee*, 172 U.S. 516, 529-30, 19 S.Ct. 269, 274-75, 43 L.Ed. 535 (1899). In addition, the Attorney General's authority under Oregon law "does not make the alleged injury fairly traceable to his action" as required by Article III. *Southern Pac. v. Brown*, 651 F.2d 613 (9th Cir.1980); *Long v. Van de Kamp,* 961 F.2d 151, 152 (9th Cir.1992). Any claim against the Attorney General based on the enforcement or nonenforcement of the criminal laws is not a justiciable case or controversy. *Id.*

Plaintiffs argue that it is appropriate to name Attorney General Kulongoski a defendant, because he does have enforcement and investigatory powers when ordered to use them by the Governor, and the Governor is also a party. Plaintiffs rely on *Quill v. Koppell,* 870 F.Supp. 78, 79 (S.D.N.Y.1994). However, the Governor has not directed the attorney general to enforce Measure 16. (Affidavit of Theodore R. Kulongoski (# 143)). Plaintiffs also claim that the attorney general is properly a defendant because he has issued a legal opinion regarding Measure 16, and that this role is sufficient. The court does not agree. Plaintiffs' constitutional claims against the State of Oregon, the Governor, and the attorney general are barred by Eleventh Amendment immunity. In addition, the claims against the attorney general are dismissed for lack of justiciability.

IV. CONCLUSION

The appropriate parties to assert or defend claims in this action are:

1. Plaintiff terminally ill patients Eric Dutson and Janice Elsner,

2. Plaintiffs Maryville Nursing Home and Willows Residential Care Facility,

3. Plaintiffs Dr. Petty, Fritz, and June Beck, and Sister Bernards, for First Amendment claims only,

4. Defendants District Attorney Harcleroad, and members of the Oregon Board of Medical Examiners,

5. Intervenor defendants Goodwin, Lee, and Sinnard,

6. Intervenor defendant Dr. Levin, and

7. Intervenor defendant Tim Shuck.

DATED this 3rd day of August, 1995.

/s/ Michael R. Hogan
UNITED STATES DISTRICT JUDGE

[file mark: Apr. 11, 1997]

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

GARY LEE, M.D. individually and on behalf of his patients; WILLIAM PETTY, M.D., individually and on behalf of his patients; ERIC DUTSON, individually and as co-representative of a class of persons who have the disability of a terminal disease even with medical treatment; JANICE ELSNER, individually and as co-representative of a class of persons who have the disability of a terminal disease even with medical treatment; CLAUDINE STOTLER, individually and as a representative of a sub-class of person who have the disability of a terminal disease even with medical treatment and who are being, or will be treated at the Oregon Health Sciences University Hospital; JEFFREY M. WEINKAUF, individually and as a representative of a class of Oregon patients who have a possibly terminal disease absent medical treatment; FRITZ BECK; JUNE BECK; THE WILLOWS HOME, INC.; SISTER GERALDINE BERNARDS, individually and as Administrator of Maryville Nursing Home, Inc.; and

MARYVILLE NURSING HOME, INC., Plaintiffs-Appellees, Cross-Appellants	)	
	)	Nos. 95-35804,
vs.	)	95-35805,
	)	95-35854,
STATE OF OREGON; DOUGLAS F. HARCLEROAD, in his official capacity as the District Attorney for Lane County, Oregon, and as a representative of the class of all district attorneys in the State of Oregon; JOHN KITZHABER, in his official capacity as Governor of Oregon; TERRY L. CONNOR, D.O., in his official capacity as Chairman of the Oregon Board of Medical Examiners; EDWARD A. HEUSCH, D.O., in his official capacity as Vice-chairman of the Oregon Board of Medical Examiners; CATHERINE M. NATER, in her official capacity as Secretary of the Oregon Board of Medical Examiners; JOHN W. GRIGSBY, M.D., in his official capacity as a member of the Oregon Board of Medical Examiners; SARAH S. HENDRICKSON, M.D., in her official capacity as a member of the Oregon Board of Medical Examiners; GEORGE A. PORTER, M.D., in his official capacity as a member of the Oregon Board of Medical Examiners; JAMES H. SAMPSON, M.D., in his official capacity as a member of the	)	95-35948, 95-35949 (cross appeal)
	)	ORDER

Oregon Board of Medical Examiners; ROSEMARY C. LEE SELINGER, M.D., in her official capacity as a member of the Oregon Board of Medical Examiners; FRED R. STARK, M.D., in his official capacity as a member of the Oregon Board of Medical Examiners; MARALYN E. TURNER, in her official capacity as a member of the Oregon Board of Medical Examiners; J. BRUCE WILLIAMS, M.D., in his official capacity as a member of the Oregon Board of Medical Examiners; PETER KOHLER, in his official capacity as the President of the Oregon Health Sciences University; LEE SWANSON, JR., HERBERT ASCHKENASY, ROBERT L.R. BAILEY, DIANE CHRISTOPHER, BOBBY LEE, WALTER R. MILLER, ESTHER PUENTES, GEORGE E. RICHARDSON, JR., RONDA L. TROTMAN REESE, JIM WILLIS, AND JANICE J. WILSON, in their official capacities as members of the Oregon State Board of Higher Education; and OREGON HEALTH SCIENCES UNIVERSITY HOSPITAL,

Defendants-Appellants, Cross-Appellees

and

PETER GOODWIN; BARBARA COOMBS LEE; ELVEN SINNARD; MICHAEL VERNON; TED LEVIN; and TIM SCHUCK,
Intervenors-Appellees, Cross-Appellees.

BEFORE: GOODWIN and BRUNETTI, Circuit Judges, and KING,[4] District Judge.

Appellees and cross-appellants' petition for rehearing is DENIED.

[4]Hon. Samuel P. King, Senior United States District Judge for the District of Hawaii, sitting by designation.

**[Oregon Ballot Measure 16
is set out as an appendix to the
Ninth Circuit opinion,
supra at 16a.]**

Nos. 95-35804, 95-35805, 95-35854, 95-35948, 95-35949

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

[file mark: Mar. 13, 1997]

GARY LEE, M.D., et al.,
Plaintiffs-Appellees / Cross Appellants,
&
FRITZ BECK, JUNE BECK, and SISTER GERALDINE BERNARDS,
Plaintiffs-Appellees,
v.
STATE OF OREGON, et al.,
Defendants-Appellants / Cross Appellees,
&
PETER GOODWIN, BARBARA COOMBS LEE, ELVEN SINNARD, TED LEVIN, and TIM SCHUCK
Intervenors-Appellants / Cross Appellees

Appeals from the United States District Court
for the District of Oregon, No. CV-94-06467-MRH

PETITION FOR REHEARING

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* * *

PETITION FOR REHEARING

Appellees and Cross Appellants Lee et al. petition for rehearing pursuant to FRAP 40, Circuit Rule 40-1, and the instructional memorandum from the Office of the Clerk.

STATEMENT OF COUNSEL

The undersigned counsel express their belief, based upon a reasoned and studied professional judgment, that the panel deciding this case has overlooked the following material points of fact or law in the decision:

1. In deciding that the health care providers have no standing, the panel overlooked criminal and malpractice liability for noncompliance with Measure 16. *See* § I.

2. In deciding that the case of the health care providers is not ripe, the panel overlooked criminal and malpractice liability for noncompliance with Measure 16. *See* § II.

3. In deciding that terminally ill patients with a history of depression have no standing, the panel overlooked the fact that a lowered standard of care, an increased risk of harm, a loss of legal redress, and a badge of inferiority are sufficient harms for standing. *See* § III.

4. In deciding that terminally ill patients with a history of depression have no standing because their risk is not more imminent, the panel overlooked the applicable supreme court precedent for cases of this nature. *See* § IV.

5. Because the terminally ill patients have standing, the health care provider plaintiffs ought to be able to assert jus tertii

standing for their terminally ill patients with a history of depression. *See* § V.

6. In deciding that the health care provider plaintiffs have no standing because Measure 16 itself did not require informed consent dialogues, the panel overlooked the fact that the duty, regardless of its source, created an imminent, concrete, and particularized injury. *See* § VI.

7. In opining that plaintiffs probably would not meet the causation and redressability elements of standing, the panel misapprehended the fact that both clearly exist. *See* § VII.

ARGUMENT

I. In Deciding That the Health Care Providers Have No Standing, the Panel Overlooked Criminal and Malpractice Liability for Noncompliance with Measure 16.

The panel held that the health care plaintiffs "lack standing to bring this [forced participation] claim because Measure 16 does not provide for any penalty, criminal or otherwise, for violations of the challenged provisions." Slip op. at 2072. In so doing, the panel overlooked the fact that the health care plaintiffs would be subject to malpractice liability, Or. Rev. Stat. § 677.095 (objective duty of care imposed), and, under Measure 16, to criminal liability. Measure 16 provides:

> The penalties in ORS 127.800 to 127.897 [Measure 16] do not preclude criminal penalties applicable under other law for conduct which is inconsistent with the provisions of ORS 127.800 to 127.897.

§ 4.02(4); Or. Rev. Stat. § 127.890(4). Measure 16 thus specifically contemplates criminal liability for conduct inconsistent with it even if the Measure itself neither contains a specific penalty for, nor specifically classifies, such conduct.

Moreover, Or. Rev. Stat. § 161.555(3) provides:

> An offense defined by a statute of this state, but without specification as to its classification or as to the penalty authorized upon conviction, shall be considered a Class A misdemeanor.

A Class A misdemeanor may be punished by up to one year in prison, Or. Rev. Stat. § 161.615(1), and/or up to a $5,000 fine. Or. Rev. Stat. § 161.635(a).[5]

The panel erred because, even apart from medical malpractice liability, it overlooked the fact that the health care plaintiffs would be subject to criminal liability for failure to conform to the requirements of Measure 16. The panel determined that such "an asserted injury would probably be sufficiently 'imminent' for purposes of standing," citing case law that says one need not

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[5]A possible objection needs to be dealt with in advance. Oregon law provides that "[a]n offense is conduct for which a sentence to a term of imprisonment or a fine is provided by any law of this state or by any law or ordinance or a political subdivision of this state. An offense is either a crime or a violation or an infraction." Or. Rev. Stat. § 161.505. Thus, it might be argued that since conduct by health care providers inconsistent with Measure 16 is not specifically penalized, it is not an "offense" — and therefore does not fall within the purview of Or. Rev. Stat. § 161.555(3), which employs the word "offense" as its operative term. Such an argument fails, however, both because it is circular and because it would render Or. Rev. Stat. § 161.155(3) meaningless: the provisions of Or. Rev. Stat. § 161.155(3) were specifically included in Oregon law to provide for penalties for conduct not otherwise penalized by imprisonment or fine under Oregon law.

"risk arrest or prosecution in order to have standing to challenge the constitutionality of a criminal statute." Slip op. at 2072 (citation omitted). Under the threat of criminal prosecution for failure to comply with Measure 16, the health care providers have standing.

II. In Deciding the Case of Health Care Providers Is Not Ripe, the Panel Has Overlooked Criminal and Malpractice Liability for Noncompliance with Measure 16.

With respect to the health care plaintiffs, the same risk of criminal and malpractice liability mentioned in the preceding section was also overlooked by the panel when it determined that the plaintiffs' claim was not ripe because they faced, "at worst, . . . a civil enforcement action." Slip op. at 2073.

III. In Deciding that Terminally Ill Patients with a History of Depression Have No Standing, the Panel Overlooked the Fact that a Lowered Standard of Care, an Increased Risk of Harm, a Loss of Legal Redress, and a Badge of Inferiority Are Sufficient Harms for Standing.

The panel held that the terminally-ill plaintiffs did not have standing to raise an equal protection challenge despite the lower standard of care to which they were subjected by Measure 16 because "the mere reduction in the standard of care owed by doctors to their terminally-ill patients is insufficient to confer standing without an allegation that an individual patient has suffered or will imminently suffer some concrete and particularized injury as a result of the reduction in the standard of care." Slip op. at 2071 n.5.

The panel misapprehended the argument, for the lowered standard of care is itself a concrete and particularized injury, making terminally ill persons second class citizens subject to a lower standard of care in the full scope of their medical care, including diagnosis of terminal illness, diagnosis of depression, and prescription of medication. An injury is an injury, regardless of its size. *Cf. Everson v. Board of Education*, 330 U.S. 1, 48-49 (1947) (Rutledge, J., dissenting). Moreover, the panel ignored the decision of the Oregon Supreme Court rejecting any lowered, subjective standard of medical care. *Rogers v. Meridian Park Hospital*, 307 Or. 612, 772 P.2d 929 (Or. 1989) (en banc).

The panel ignored the fact that the increased risk of harm the terminally ill plaintiffs suffer because of the lowered standard of care is itself a cognizable injury for standing purposes. *DiMarzo v. Cahill*, 575 F.2d 15, 18 (1st Cir. 1978), *cert. denied* 439 U.S. 927 (1978) (prison inmates at increased risk of fire hazard did not need to prove imminent threat of fire for standing).

The panel also ignored the fact that the lowered standard of care stripped the terminally-ill plaintiffs, their estates, and their families of legal redress, which is a concrete and particularized injury. For example, if a patient believed to be terminally ill who is in the midst of undiagnosed depression requests assistance in suicide — an imminently likely (not merely remotely possible) event given the evidence from suicidology experts presented in the record and in the appellees' and cross appellants' brief on appeal (but overlooked by the panel) — the standard of care afforded her in (1) the diagnosis of whether she is terminally ill, (2) the evaluation of whether she is capable of making a fully rational and volitional decision, and (3) the provision to her of a prescription intended to be efficiently lethal are all governed by a good-faith, subjective standard,

rather than the usual obbjective standard of medical care. This deprives her and those making legal claims as a result of her injury and/or demise of legal remedies in the form of medical malpractice claims, criminal charges, civil charges such as battery, and disciplinary charges.

The panel also overlooked the fact that Oregon has imposed on terminally ill patients a badge of inferiority, making them second class citizens by allowing them to have assisted suicide, something considered so dangerous and wrong that it is prohibited to all other Oregon citizens. For terminally ill persons, however, the state has decided not to assert its unqualified interest in protecting human life. This discrimination is in the nature of racial apartheid, in that the mere classification of persons into groups with differing legal protections on the basis of the disability of terminal illness is an injury. *See Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432, 448, 450 (1985).

IV. In Deciding that Terminally Ill Patients with a History of Depression Have No Standing Because Their Risk of Death Against Their Will Is Not More Imminent, the Panel Overlooked the Applicable Supreme Court Precedent for Cases of This Nature.

In rejecting Ms. Elsner's standing based on the panel's characterization of the District Court's holding on standing, the panel rejected the notion that the standing of Ms. Elsner should be recognized because "there was a danger Elsner would only have standing after she was dead or close to death, and that if Elsner did not have standing, nobody would." Slip op. at 2069. The panel decided that Elsner's threat of danger was "so speculative" that the described rationale for Elsner's standing was "almost as applicable to every individual in the State of Oregon." *Id.*

The panel is wrong as to the terminally ill patients' legal standing on the basis of their imminent risk for assisted suicide itself. The panel ignored the point of the first rationale of the district court, namely, if a terminally ill person with a history of depression does not have standing to challenge a statute which imposes on her a lower standard of care and may have lethal consequences then only a similarly-situated person who *also* met one of the following criteria would have standing: (1) suicidal depression has gone undiagnosed due to the flawed safeguards and the depression has caused the patient to actually request and receive a lethal prescription or (2) suicidal depression has gone undiagnosed, assistance in suicide has occurred, and the personal representative has challenged the statute.

Expecting a person in the first situation to bring suit is ludicrous. No person in such a condition could or would bring suit due to the depression and the fact that she is receiving what she wants, i.e., assistance in suicide.

The second situation asks a person to await death so that her personal representative may challenge the statute responsible for the death. Such relief gives little benefit to the deceased person. If one need not await a criminal charge to challenge a statute, then one ought not have to await death.

The panel's facile dismissal of the terminally ill patients with the comments that (1) their harm is not sufficiently imminent and (2) just because no one has standing doesn't mean someone has to have standing, slip op. at 2069, overlooks what the district court clearly saw, namely, this sort of case is classically sui generis and calls for a most careful application of the principles underlying the standing rules.

The analysis must begin with the U.S. Supreme Court's observation in *Cruzan v. Director, Missouri Dept. of Health*,

497 U.S. 261 (1990), in the context of withdrawing life-sustaining nutrition and hydration which would lead to death:

> We think it self-evident that the interests at stake in the instant proceedings are more substantial, both on an individual and a societal level, than those involved in a run-of-the-mine civil dispute. . . . An erroneous decision not to terminate results in maintenance of the status quo; the possibility of subsequent developments such as advancements in medical science . . . . *An erroneous decision to withdraw life-sustaining treatment, however, is not susceptible to correction.*

Id. at 283 (emphasis added).[6]

The principle is that special notice must be taken of the seriousness of the consequences in determining applicable rules of law, and safeguards must be more stringent as the risks grow greater. This fundamental principle of law is applicable to Measure 16, both as to the substantive safeguards allegedly protecting incompetent persons from self harm and assistance in suicide and as to the principles governing who has standing to

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[6]The Supreme Court continued, taking note of the fact that in certain cases the substantive risks are so high that adjustments must be made in the law to protect those rights:

> In *Santosky*, one of the factors which led the Court to require proof by clear and convincing evidence in a proceeding to terminate parental rights was that a decision in such a case was *final and irrevocable*. *Santosky*[*v. Kramer*], 445 U.S. [745,] 759 [(1982)]. . . . The same must surely be said of the decision to discontinue hydration and nutrition of a patient such as Nancy Cruzan which all agree *will result in her death*.

Cruzan, 497 U.S. at 283 (emphasis added). The Supreme Court catalogued the progressive range of standards of proof required by the Due Process clause as the seriousness of the matter at issue increased. *Id.* at 282-83.

seek judicial review the safeguards. With death at issue, and assistance in death for incompetent persons more specifically at issue, it is unthinkable that in a constitutional government there should be no one with standing to seek judicial review of serious claims of such dire and invidious discrimination.

The United States Supreme Court has held that in unique circumstances, comparable to the present one, the rules of standing must be applied with circumspect attention to their purposes, not with a mechanical recitation of the application of the rules in ordinary cases. The Supreme Court's approach is seen clearly in the cases where taxpayers where taxpayers have been permitted to challenge violations of the Establishment Clause.

Such standing was not initially recognized as appropriate by the Supreme Court. In the case of *Valley Forge Christian College v. Americans United for Separation of Church and State*, 454 U.S. 464 (1982), the Court rejected taxpayer standing to challenge a transfer of federal property to a religious organization without compensation in language substantially similar to that of the panel in the present case. The Court forcefully rejected the lower court's "conviction that the enforcement of the Establishment Clause demands special exceptions from the requirement that a plaintiff allege "'distinct and palpable injury to himself,' . . . that is likely to be redressed if the requested relief is granted."" *Id.* at 488 (citations omitted). The Court repudiated the view it saw in a concurring opinion of the lower court that:

> To satisfy "the need for an available plaintiff," and thereby to assure a basis for judicial review, respondents should be granted standing because, "as a practical matter, no one is better suited to bring this lawsuit

> and thus vindicate the freedom embodied in the Estab lishment Clause."

Id. at 489 (citations omitted). The Court rolled out the well-known quote that "[t]he assumption that if respondents have no standing to sue, no one would have standing, is not a reason to find standing," *id.* at 489 (citation omitted), and concluded with the declaration that it would not "countenance such a departure from . . . Article III . . . ." *Id.* at 489-90.

Justices Brennan, Marshall, and Blackmun dissented, with an argument which would later be adopted by the Court itself. Justice Brennan noted the impulse to avoid difficult legal questions by a resort to 'standing to slam the courthouse door against plaintiffs who are entitled to full consideration of their claims on the merits.'" *Id.* at 490 (citation omitted). He observed how the majority "waxe[d] eloquent" about standing principles, but that "*not one word is said about the Establishment Clause right that the plaintiffs seek to enforce.*" *Id.* at 491 (emphasis in original). After recounting the basic requirements of Article III standing, he noted that "the existence of Art. III injury 'often turns on the nature and source of the claim asserted.'" *Id.* at 491-92, *quoting Warth v. Seldin*, 422 U.S. 490, 500 (1975). He continued, "To construe that Article to deny standing 'to the class for whose sake [a] constitutional protection is given,' simply turns the Constitution on its head." *Id.* at 493 (citations omitted). He noted that "'standing is not to be denied simply because many people suffer the same injury,'" *id.* at 496-97, *quoting United States v. SCRAP*, 412 U.S. 669 (1973), and that "the Constitution draws no distinction between injuries that are large, and those that are comparatively small." *Id.* at 497, *citing Everson v. Board of Education*, 330 U.S. 1 (1947) (Rutledge, J., dissenting). He also rejected the majority's concern about "the indirectness of the taxpayer's injury," *id.*, noting that "*as a matter of Art. III standing*, if the causal

relationship is sufficiently certain, the length of the causal chain is irrelevant." *Id.*, *citing Warth v. Seldin*, 422 U.S. at 505 (emphasis in original). Because it was "clear . . . that one of the major purposes of the Establishment Clause was to prevent the use of tax money for religious purposes," he concluded, "*[t]he taxpayer was the direct and intended beneficiary of the prohibition on financial aid to religion.*" *Id.* at 504 (emphasis in original).

This dissenting view became the prevailing view in Justice Brennan's opinion for the Court in *School District of Grand Rapids v. Ball*, 474 U.S. 373 (1985), where taxpayer standing was recognized for an Establishment Clause challenge. The Court specifically noted that the lower court of appeals "recognized no evidence of specific incidents of religious indoctrination in this case [in a program where public school teachers taught some classes in religious schools]." *Id.* at 388. However, the Court spoke of the difficulty there would be for other plaintiffs to recognize and bring a case with specific incidents, including the fact that there would be "no incentive [for others] to detect or report any specific incidents," so that "the lack of evidence of specific incidents . . . is of little significance." *Id.* at 389.

The Supreme Court's approach to the unique situation of the Establishment Clause is the approach taken to the present unique situation by the district court in the passages cited by the panel. The district court correctly applied the principles of standing in this unique situation, while the panel did not. While full development of the parallels is beyond the limited space provided by this petition (and full rebriefing solely on the issue of standing would be in order), the following principles are readily apparent. The notion (*supra*) that a loss of an objective standard of care is to small a harm for standing is erroneous. The notion that specific incidents of harm must already be

occurring for standing to be recognized is erroneous. Just as the protection of taxpayers was a central thrust of the Establishment Clause, so that they have standing, the plain language of the Equal Protection Clause is that "life" is to be protected from equal protection violations, so that those who suffer an increased risk to their lives clearly have standing to challenge the assisted suicide regime which puts them at risk. Finally, the fact that terminally ill patients with a history of depression are the best challengers to an assisted suicide law which would avoid review otherwise absent someone's irreversible death means that in these unique circumstances their standing should be recognized.

V. Because the Terminally Ill Patients Have Standing, the Health Care Provider Plaintiffs Ought to Be Able to Assert Jus Tertii Standing for Their Terminally Ill Patients with a History of Depression.

If, as argued, persons such as Elsner have standing, then the health care providers ought to be able to assert the interests of their patients suffering the same asserted injury as Elsner. Slip op. at 2069.

VI. In Deciding That the Health Care Provider Plaintiffs Have No Standing Because Measure 16 Itself Did Not Require Informed Consent Dialogues, the Panel Overlooked the Fact that the Duty, Regardless of Its Source, Created an Imminent, Concrete, and Particularized Injury.

The panel concluded that one reason the health care provider plaintiffs would not have standing is because their duty to advise patients of the Measure 16 option in informed consent dialogues (which would violate religious liberty rights) arises under existing Oregon statutes (prescribing informed consent),

not Measure 16. Slip. op. at 2072 n.6. The panel has ignored the fact that if Measure 16 did not exist there would be no problem, but because it exists these plaintiffs have an imminent, concrete, and particularized injury, i.e., the moment Measure 16 goes into effect they must provide information to patients about assisted suicide in violation of their religious liberty rights. The panel overlooked these facts when it stated that "[b]ecause this challenge is directed at the informed consent requirements of state and federal law, and does not go to the validity of Measure 16 itself, we do not consider this claim." *Id.* The panel has confused a cause of action with the imminent injury which gives standing. The plaintiffs suffer an imminent injury because of Measure 16, which gives them standing even though Measure 16 does not itself require the informed consent.

VII. In Opining That Plaintiffs Probably Would Not Meet the Causation and Redressability Elements of Standing, the Panel Misapprehended the Fact that Both Clearly Exist.

The panel overlooked the presence of causation and redressability, stating its doubt that these necessary elements of standing also existed. Slip op. at 2070 & n.3. For example, Elsner has several injuries from an unenjoined Measure 16, including a lowered standard of care. This injury would be caused by these officials ignoring the unconstitutional discrimination of Measure 16 and implementing Measure 16 by failing to enforce the existing criminal ban and professional disciplinary ban on assisted suicide. Similarly, this problem would be redressed by an injunction, as the district court's injunction has redressed it to date.

CONCLUSION

For the reasons stated, these appeals should be reheard.

Respectfully submitted,
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